Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 05 A M Physician TERGUSON SEPTEMBER 24 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE REHABILITATION EXTENDED CARE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Months Days 1 ☑ M 2 □ F Director 03 MD 06 215-40-6348 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 √Yes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 21213 U.S.A. Funeral 2623 East Oliver Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after Y Yes 2 No ff Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>8</u> Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Plumber 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any linjury or other traumatic evonce. Fannie Clark Robert Ferguson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type. Print) 3422 Carriage Hill Circle #103, Randallstown Bryant Ferguson-Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Garrison Forest Vet 10/1/08 Owings Mills, Md 22. Name and Address of Facility 21. Signature of Funeral Service Lidensee March F/H West 4300 Wabash Ave, Baltimore, Md March F/H West 4300 Wabash Ave, Baltimo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Immediate Cause (Final disease or condition resulting in death) HEPATO CELLULAR CARCINOMA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of and The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ CANCER 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown WITH certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐Yes 2 ☑No 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ೭ rulle 50272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

341

State Registrar 71 Date filed (Month, Day, Year) SEP 2 9 2008 3700 LOCO RAVEN BOULEVARO, BANTIMORE, MARTIAND 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day P^{M} **Physician** 09 22 2:30 STELLA HELEN GAST 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Arundel Anne Pear Tree Assisted Living Pasadena Birthplace (State or Foreign Country) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Hours Months Days 1 □ M 2 🗷 F 96 Maryland 215 03 6288 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai popartment of Health and Mental Hygiene. International titlems 23a or 28a-f show Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual paractical and 1 ☐ Yes 2 No Director Anne Arundel Pasadena MD Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 .S.A. 1755 Poplar Ridge Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: 2 White 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Loeffler Max Gast ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, MD 2 20c. Location - City or Town, State Jack E. Phebus - Son 1743 Poplar Ridge Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill9/26/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ 21. Signature of Funeral Service Licensee Gonce Funeral Home, 21122 169 Riviera Dr. Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final (1P90 **Physician** resulting in death) /Medical Due to lor as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit and los Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Month Day ☐Yes 2 ☐No certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 1 ☐ Yes 2/ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred 27. Manner Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

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filled in by the fur 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

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State Registrar

(Check only one)

31. Date filed (Month.

29b. Signature and title of certifie

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DHMH 17 Rev 1/2001

and manner stated.

32. Registrar's

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Hans F. Graf September 25, 2008 11:46 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Morningside House Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** Days 1 🕱 M 307-05-1904 91 July 8, 1917 Germany Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 3004 North Ridge Road Apt 212 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 🖾 No Specify. þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Construction 12 should be filed w h and Mental Hygies 7 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: It item 27 Is marked on any Injury or other trainment Fritz W. Graf Adelaide Wickenhauser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10659 Breezewood Drive; Woodstock, MD 21163 Hans F. Graf, Jr. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Highland Lawn Cemetery 10/3/2008 Terre Haute, IN 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) verrovasa Moneta Due n (or as a consequence of): /Medical Examiner Achero Monet if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9☐Unknown 9 Unknown ģ The law requires that signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ pe 1 | Yes 2 | No 3 | Probably 4 | Uaknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 ☐ No certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ded Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760 Physiclan: within 24 hours after death.

To the Funeral Director: After this or Attending Hospital To the !

Baltimore, Maryland 21215-0036

State Registrar

Shallunmale 31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier

repte 9650 32. Registrar's Signature MALO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

000

53150

29d. Date signed (Month, Day, Year)

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Division of Vital Records. P.O. Box 68760.

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ss 1 an of Hea item ;		20a. Method of Disposition		20b. Place	of Disposition tery, crematory	Name of	1		20c. Location			
Page ment ant: If		1 🛱 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			TIMORE			/2008	REISTE	RSTOW	N, MD	
Depart Import any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC.										
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exal	nysician: To the bes miner: On the basis and manners	of examination	dge, death occ and/or investig	urred at the ti ation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s	s)
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	/Medic Examin		4a. Facility Name (If not institution, given JEWISH CONVALES	SCENT & NU	NT & NURSING BAL				of Death	T	4c. County of Death BALTIMORE h 9. Birthplace (State or Foreig			· hw
ľ	Funeral Director			Sex 1 M 2 F 7. A	ge (In yrs. last i 78	Vrs.	If Under 1 Yea Months Day		h Air	B. Date of Birth (Month, Day,)7/22/19	930	9. Birthpl Coun	ARGEN	TINA
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						0d. Inside C	ity Limits
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	3a or 2	i Dire	10e. Street and Number 3405 POWHATAN A	VENUE			10f. Zip Code	2121	6	11	10g. Citizen of What C			
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Maryland	1 and 2 should I Health and Men em 27 is marke other traumatic		19a. Informant's Name/Relationship RENATE MILEWICH				ng Address <i>(Stre</i>						^{Code)} 2120	9
Baltimore,	Pages 1 a nent of Hei int: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 penation 5 Other (Special Control of Cont			tery, crer	sition (Name of natory or other p SERVICE		Dai 09/26/		20c. Location - TOWS	ON, M		
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	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying cause	given in Part	1.	23e. Did tob	oacco use cont es 2 🗌 No	ribute to th	^	death?
I Records,	The ate ha	Completed								24a. Was a autops perform	ned?	death?	psy findings npletion of c	available cause of
of Vital	Physician: this certificated director, I	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ➡lo	Hospital: 1 ☐ Inpa	tiont 2 TED/	Outpatien	it 3 DOA	Whon is		Check only on		os (Coosih	41	
n of	ding Phys h. After this funeral dii	on: To	27. Manner of Ceath Natural 5 Pending	28a. Date of In (Month, D	iury 28b	outpation Time of Injury	28c. In	ury at ork?	28	d. Describe ho			//	
Division	I or Attending after death. Diractor: Aftel I in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not investigation	be 28e, Place of I	M 1 Yes 2 No					8f. Location (Street and Number or Rural Route Number,				nber,
Dİ	rital or A		4 Homicide	bullaing,	etc. (Specify)					City or Towr				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edical	29a. Certifier Check only one) Certifying P	hysician: To the bes minar: On the basis and manner:	of examination	dge, death and/or in	n occurred at the vestigation, in my	time, date a opinion, de	nd place, an ath occurred	d due to the cand at the time, do	ause(s) and ma ate and place,	and due to	ated. the cause(s	s)
	To the To the comp	M	29b. Signature and title of certifier	u vs			- ha	nse number UUS	17.		9d. Date signe			c8.
	6		30. Name and address of person who	completed cause of	death (Item 23)	a) (Type,	Print) 2 4 3 h	WB	elin	elles 2	Sept	Be	ChM	V20.
. 7	Sta		31. Date filed (Month, Day, Year)		trar's Signature	1			• •					
211	Registr	al	SEP 2 9 200	LEGA	A. A.	goon								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	1- State of Maryland / Department of Health and Messages Certificate of Death		ene 008	31006	
Physici /Medic		Kose Holmes s	2. Date of Death Month	Day 27 20		
Examin Funeral	ier		8. Date of Birth (Month, Day 12/6/19	4c. County of Dea	rthplace (State or Foreign	
Director		215-01-2281 1□ M 2X F 91 Yrs. Months Days Hours Min. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	12/6/19	16 Ma	ryland 10d. Inside City Limits	
he Maryla 28a-f shor	ector	MD Baltimore Halethorpe	100	g. Citizen of What C	1 □ Yes 💥 No	
h with 1	al Dir	10e. Street and Number 10f. Zip Code 21227		USA	oundy?	
portiliiole; Mal ylalid 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental tyglene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f show appringing or other treumatic event, the Medical Evaninar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2☑ No If Yes, specify Cuban, Mexican, Puerto R 1 □ Yes 2☑ No Specify:	cify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify: W		
d within 72 h giene. ar than "netu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	g	6b. Kind of Busines: Own hom		
ar yrarru should be file and Mental Hy s marked oth umatic event,	To Be (ce C. Co	limore		
and 2 shoelth and n 27 Is m		19a. Informant's Name/Relationship (Type, Print) Barbara Kendrick / Daughter 19b. Mailing Address (Street and Number or Rural 5861 Woodvalley Road, E				
Pages 1 ar		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 10 10 10 10 10 10 10 10 10 10 10 10 10 1		Oc. Location - City o		
permit. Pages Department of Importent: If it any Injury or o		*4 Donation 5 Other (Specify) Meadowridge Mem. Pk. 10/2/ 21: Signature of Funeral Service Licensee 22. Name and Address of Facility Hub		Elkridge, neral Hom		
0 83 E 5 8		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			1229 Approximate	
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SIOII OF tending Phy Beath. tor: After this the funeral c	Certification: T	27. Manner of Deal 28a. Date of Injury 28b. Time of 28c. Injury at	w injury occurred	,		
ol or Att s after de l Direct	Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Str City or Town,		Rural Route Number,	
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, da	te and place, and di	ue to the cause(s)	
To T Com	M	29b. Signature and title of certifier 29c. License number 0 553 91		entermizer	29, 2008	
_ 5		30. Name and address of person who completed cause of death from 23a) (Type, Print) Ming V, M 3320 Sensun Avenue, But more,	A .	4	21227	
Sta Registr	_	31. Date (i)ed (Nonth, Day, Year) SEP 2 9 2008			/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#8 perFH, G884, 10/9/08, WS
State of Maryland Department of Health and Mental Hygiene 2 1 18 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 5, 2008 **Physician** 3:00 A M Gail Hardester /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2617 Braun Avenue Halethorpe If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Data Year) 1 ☐ M 2 H Days 50 218-74-5630 Dec. 19. 1957 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2▼ No Director MD Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 United States 2617 Braun Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married Married 1 □Yes 2 →No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Business Entrepeuner 7 Father's Name (First, Middle, Last) Ed Higdon 18. Mother's Name (First, Middle, Maiden Surname) Be Margarite Redmon ပ 19a. Informant's Name/Relationship (Type. Print)

David Hardester - Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2617 Braun Avenue, Halethorpe, MD 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place)
Meadowridge Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-30-2008 ELkridge, MD Memorial Park 21. Signal of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) METAINA CHOLANGIOCARE NON Due to (or as a consequence of) Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

To the Hospital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certific filled in by the funeral director, n 24 hours a within 24 hountly the total to the total the total tot

Funeral

Director

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if than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinat once.

Physician

/Medical

Examiner

and burial-tran

attending physician for use as the buria

cate has been signed by the page 2 should be detached

certificate

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

Registrar

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MD

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2008 SEPTEMBER

AMDYA.

BALTIMORE, 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician PAUL LIONEL HIGGINS 9 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto Washington Medical Center Glen Burnie Anne <u>Arundel</u> 8. Date of Birth (Month, Day, Year) 12/6/1932 Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** Months Days Hours 1 M 2 □ 101 24 4098 75 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r 407 Phelps Ave. 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. ²□No 1951 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by Specify: 3 X Widowed 4 ☐ Divorced 1955 Year or Dates: White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Dept of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Leo Patrick Higgins ျှ Rosemary Riley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul L. Higgins, Jr. Son 8084 Woodholme Circle Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) MDVeterans Cem 9/26/2008 Crownsville, MD 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Emeral Service Licensee Home, 21122 169 Riviera Pasadena, MD Dr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause or thine. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of) physician Physician/Medical as IF FEMALE: ed by the attendin detached for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à a pe 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an auto-performe 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Dath Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending 1 Natural Accident Injury 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Division or Vital Records, To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ⊀ filled in by

> State Registrar

Medical

29a. Certifier

30. Name a

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

2*

s of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 09 EDITH ELEANOR HAYSLUP 21 2008 5:55 A[™] 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Severna Park Genesis Eldercare Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Hours 1 □ M 2 🗷 F Maryland 218 05 1750 94 5/16/1914 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 21060 U.S.A. 406 Tydings Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland Match Co. Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Agnes Foster Durse Cain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21060 <u>Melva Pau</u>l - daughter 406 Tydings Ct. Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Entombment 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/25/08 Baltimore, MD Loudon Park Cem 4 Donation 5 X Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses GJ Gonce Funeral Home, 21122 Dr. Pasadena, MD 169 Riviera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of)

Baltimore, Maryland 21215-0036 Department of Health a Important: If item 27 is any Injury or other trau Physician /Medical Examiner

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1 - For State Registrar

10a. State

MD

10e. Street and Number

10

20a. Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

Director

Funeral

ģ

Completed

2

5. Social Security Number

Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

and Mental Hygiene.

filed within 72 hours after death with the Maryland

attending physician and for use as the burial-transî Physician/Medical To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director: After this certificate has bo completely filled in by the funeral director, page 2 sh

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		pic pregnancy r (specify)		Date of delivery Month Day Year	
Part II. Other significant conditions	contributing to death but not resulting in the underlyi	ng cause given In Part I.	23e. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unkno	
			24a. Was an autopsy performed? 1 □Yes 2□No	b. Were autopsy findings availa prior to completion of cause of death? 1 □Yes 2 □No □	
25. Was case referred to medical		26. Place of Death	(Check only one)		
examiner? 1 ☐ Yes 2 ∑ 470	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 [DOA Other: Nursing Hom	e 5 ☐ Residence 6 ☐ 0	Other (Specify)	
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at 28 Work?	3d. Describe how injury occ		
3 ☐ Suicide 6 ☐ Could not be determined		St. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one)	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	irred at the time, date and place, a ation, in my opinion, death occurre	nd due to the cause(s) and d at the time, date and plac	manner as stated. ce, and due to the cause(s)	
29b Signature and title of certifies	1	29c_License number	29d. Date sig	ned (Month, Day, Year)	

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2108

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

SEP 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Ma Registrar		partment of H Pertificate of L		-	ene g. No 2008	31011
	Physici	an	1. Decedent's Name (First, Middle, Last) Ann C. Huntzberry				2. Date of Death Month	Day Year	3. Time of Death
5	/Medic		4a. Facility Name (If not institution, give street and number)			Location of Death	_	4c. County of Dea	
	Funeral Director		5. Social Security Number 212-22-7480 1 M 2 1 Age	(In yrs. last birthday 93 Yrs.	- Oat	Fi mare If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 20	9. Bir Yea <i>r)</i> 1914 Ma	thplace (State or Foreign unity) ryland
	land ow If		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	Location				10d. Inside City Limits
	e Mary la-f sh tified a	ctor	Maryland Howard	Ellicott	City				1 ☐ Yes 2 🖺 No
	with th	Dire	10e. Street and Number 3111 West Springs Drive Ap	+ C	10f. Zip Code 2104	4 3	10	g. Citizen of What Co USA	ountry?
0	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. I will them 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	/ Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No.	ver in U.S. 13	B. Was Decedent of H. If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
-c	72 hours natural" dical Exa	eted by	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of worki	ing I	6b. Kind of Business	
717	within jiene. r than " the Mee	Completed	Elementary/Secondary (0-12) College (1-4or 5+	-) _	. DO NOT use retired eamstress	"		Clothing	
מוומ	be filed trail Hyg ad othe event,	Be	17. Father's Name (First, Middle, Last) Francesco Cimbolo	18. Mother's Name Rosa Ci		laiden Surname)			
ar ye	should ind Mer i marke imartic	မ	19a. Informant's Name/Relationship (Type. Print)	19b. Mai	iling Address (Street a			City or Town, State,	Zip Code)
Š	and 2 ealth a m 27 is	, ,	Carol Cimbolo Niece					City, MD	
allillore	Fages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	New Cath		9/30	/2008 E	oc.Location - City or altimore,	Maryland
ם ב	permit. Pages I Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Septice Licenside	F I	22. Name and Address Funeral Hot	ss of Facility Ste me of Cat	rling As onsville	hton Schwar, Inc.	ab Witzke
18			23a. Part1. Enter the disea e, or complications that caused t shock, or heart failure. List only one cause on each line						Approximate Interval Between Onset and Death
F	hysician /Medical		resulting in death)	consequence of):	chnoicl	Hemmy	nnge		76HRS
ı	Examiner	L			encephal	epatty			1/
	ausit A	Examiner	Sequentially list conditions, if any, leading to findhediate cause. Enter Underlying Cause (Disease or injury that initiated events	Response on	encephal	we			'y
,0070	sician an burial-tr	al Exa	resulting in death) Last Due to (or as a	consequence of):					
000	nincate ng phys as the	Aedical	d						
.O. DO.	To the hospital or Attending Prhysician: The law requires that the death certificate be executed within 24 hours affard death. within 24 hours affard death. within 14 hours affard death. completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death 3	B Ectopic pregnancy Other (specify)	,		23d. Date of de Month	live ry Day Year
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<u> </u>	ysiciar s certif directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien	nt 2 ☐ ER/Outpatie	ent 3 DOA Oth	26. Place of Death		e) nce 6 ⊡Other (Spe	acifu)
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	orne nospiral or Artending Priysician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	o□ cui-it- 6□ Could not be	ry - At home, farm, s . <i>(Specify)</i>			28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	le Hospi 124 hour le Funera letely fille	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
1	withir To th comp	Me	29b. Signature and title of certifier		29c. License	e number	29	d. Date signed (Mon	
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	V		30. Name and address of person who completed cause of de	calon	sulle me	D KIKKS			
	Sta Registr		31. Date file (Month, Day Year) 32. Registral	r's Signature	des s				

AND HONITABERAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and pumb Examiner HOWARD HOWARD County General bia MD Con Colum 8. Date of Birth (Month, Day, 9. Birthplace (State or F Social Security Number 6 Sex **Funeral** Days 1 M 2 □ F 06 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c, City, Town or Location 10b. County a or 28a-f show t be notified at 10a. State 1 ☐Yes 2√ No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 USA 4539 Rolling Meadows 23a must Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status Black, White, etc. the Medical Examiner filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Married Korean Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: \$ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) Electrical Electrician 9 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dalsoon Lee Woogab Hwang 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4539 Rolling Meadows Ellicott City, MD 21043 f Health attem 27 is Eunsook Hwang (Daughter) other t permit. Pages t an Department of Heal Important: If item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park 9/24/08 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gary L. Kaufman Funeral Home at MMP, Inc. 21. Signature of Funeral SA ce Licensee NO1234 Elkridge, MD 21075 7250 Washington Blvd Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GASTRIC years CANCER **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and The law requires that the death certificate be exec Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1☐ Yes 2☐ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director. Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No Certification: To 1 🗌 Yes this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ie Funeral Director: Af 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008

State

Registrar

Harbor Hospital
31. Date filed (Month, Day, Year)

2008

3001 South Hanover St. Baltimore, MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** "15 AM Hilda tiester 22,2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2XXF Yrs 86 Feb 26, 1922 PA Director 172-16-6285 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6336 Cedar Lane 21044 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√∑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: <u>م</u> er than "natural", o the Medical Exan White 3 XWidowed 4 ☐ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stenographer 12 Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob E. Burckert Anna C. Smith ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 Is not other traun Dennis Kreps 6274 Cardinals Lane, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If Its
any Injury or o
once, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Sept 25, 2008 Bayview Crematory Baltimore, MD e f Funeral Servi 21. Signa 22. Name and Address of Facility FINE FUNERAL HOME P.A. 426 CRAIN HON'S. GLEN BURNIE, MO 71061 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1 Enter the Sease, shoc or heart failure. L Immediate use (Final disease or contition resulting in dea **Physician** /Medical Due to (or as a consequence of): Examiner tabo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic physician and s the burial-trans WARK Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has tirector, page 2 s autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural
2 ☐ Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062545 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CEDAR LANE, COLUMBIA, MD 21044 Kendra Kay, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and No. 1 - State of Maryland / Department of Health and No. 1 - State of Maryland / Department of Death		Reg. No	800	31014				
	Physicia: /Medica	n	Decedent's Name (First, Middle, Last) Emma Jackson	2. Date of De Month	Day 20	Year 2008	3. Time of Death 0:24 AM				
	Examine	r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore			County of Death					
	Funeral Director		5. Social Security Number 241-42-2123 G. Sex 1	8. Date of Bi (Month, Di 12/11/	rth ay, Year) 1926	Cou	place (State or Foreign htry) Carolina				
	e Maryland	ctor	10a. State 10b. County 10c. City, Town or Location Maryland Paltimore				0d. Inside City Limits 1 X Yes 2 □ No				
	with th	DIT.	100.2 Floort Provents Channels 101. Zip Code			zen of What Cou	ntry?				
та. 036	Jrs a	by Funeral Director	1903 West Fayette Street 21223 11. Marital Status 1	pecify Yes or No Rican, etc.)	0- 1	S.A. 14. Race - Ameri Black, White, Specify: Black	etc.				
, em ma 121215-0036	iene. r than "na!	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of work (life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Farrings						
o カ yland	Q to D €	lo Be	17. Father's Name (First, Middle, Last) 18. Mother's Nam George Brown Jessie M			Sumame)					
RSC	2 sho and Is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rule)								
امدر altimore, M	Pages 1 and 2 should nent of Health and Mer ant. If Item 27 is marke ury or other traumatic.		Lillie M. Pearson/Goddaughter 201 S. Loudon Ave., Ba 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Lo	cation - City or T	own, State				
Baltin	permit. Page Department Important: If any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The 4611 Park Hgts. Ave	Derric	ck C.	Jones I	'/H, P.A.				
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sep 5 i S Due to (or as a consequence of):			c, rary	Approximate Interval Between Onset and Death				
-00	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Disease or injury) A cuto renal failure								
68760, 5	ysicie	edical Exar	that initiated events resulting in death) Last Due to (or as a consequence of): Shock liver	ience of):							
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ds, P	uires thet signed t	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension		tobacco u		the cause of death?				
l Reco	sician: The law requir certificete has been si irector, page 2 should	Completed	Diabetes mellitus type II Left intertrochanteric hip fracture	s an opsy formed? 2 1 No	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of 2 No					
of Vita	Physician: this certific el director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 negation 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 🗆 Res	idence (fy)				
Division of Vital Records, P.O.	ng fee	Certification;	27. Manner of Death 1	28d. Describe		d Number or Rui	al Route Number,				
۵	To the Hospitel or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fr	edical Cer	29a. Certifier (Check only one) 1								
	To the within To the comple	Me	29b. Signature and title of certifier M.D. 29c. License number RESOCO		.9/	e signed (Month	2008				
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FANG YIN Good Samaritan Hospital, 560 Loch R. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	aven B	lud,	Baltim	ore, MD 212:				
	Stat Registra	-de	31. Date filed (Month, Day, Year) SEP 2 9 2008 32. Registrar's Signature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** 634 Months Days Hours Min. 1 M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral OX 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or item any injury or other traumate. Black, White, etc. 1 Never Married 2 Mamed Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SING MATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ဥ 19a. Informant's Name/Relationship (Type. Print) (dung hter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State nMount 2008 rematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses RUS runera Horn 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami and Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Yea 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed ₽Z No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death. 1 Yes 2 No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Noverall 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HUTMORE 000501 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Se **Funeral** Year) Days Hours Months BALTIMORE MA 1 M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examinations to notified at 1 ☐ Yes 2 No MD Aberdeen Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 21001 items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 'natural", or Specify: If Yes, Give Year or Dates: Specify: Whit Completed by 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Şecondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, I a. M. Metal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ahason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kd. 110 MO siste Ga ereso 111-20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State 27/08 Forest HILL MP 4 ☐ Donation 5 ☐ Other (Specify) 22. Name an Address of Facility 500 HARFORD PD, BALTIMORE, MI) 2034 21. Signature of Funeral Service Ach CREMATION SPENICES-Evans Fureral Cha MOLK caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease or complications that shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consectionox of) Examiner To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Duknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Followine 2 X No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 1 ☐ Yes 2 □ No 1 ☐ Yes Division of Vital Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Residence (Specify) 100 S P1 CC 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 24 hours after death. Funeral Director; After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? **Hospital or Attending** 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 22 5008

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHARL

2008

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 24, **Physician** ^{Year} 2008 6:20 P M Susan Hanna Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1710 Fallsway Drive Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 245-72-7495 68 1940 South Carolina 14, **Director** Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 28a-f show r than "natural", or items 23a or 28a-f shout the Medical Expension of the Medical Expension of the model of 1X Yes 2 □ No Director Crofton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **IISA** 21114 1710 Fallsway Drive Funeral death 14. Race - American indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status illed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 Is marked oth any lipiry or other traumatic event 2008. Be Lillian Combs Arch Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 Fallsway Drive Crofton, MD 21114 Gene L. Jones/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 9/28/2008 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory isc . 21. Signature of Fuheral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myelogenous Leukemia **Physician** <u>3 months</u> /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 🗆 Yes 2 🗷 No Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and margine, stated. (Check only one)

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of pertified

Michael J. LaPenta MD 445 Defense Highway Annapolis MD 21401 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

29d. Date signed (Month, Pay, Year)

September 26 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Tonkins 7.35 PM **Physician** Laura Seplember 16 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Howard Ellicott City Nursing & Rehab Ellicott City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 M 2 F South Carolina 248-42-9758 June 13,1928 Director 80 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐ Yes 2 ☑ No Funeral Director Elkridge Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21075 6912 Little Brook Court 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ★ o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Vandross Henry Jenkins, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 6912 Little Brook Court Elkridge, MD 21075 Jeanette D. Wood (Daughter) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Meadowridge Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-20-2008 Elkridge, Maryland Park 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service License NO1283 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovascular Immediate Cause (Final disease or condition resulting in death) erotic Atherosci **Physician** /Medical Due to (or as a consequence of): Singuintially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Mellitus Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 은 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician sthe burial for use as After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled it by the fu

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death

Pages 1 and 2 should be filed within 72 hours after

al Hygiene.

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Saltimore, Maryland 21215-0036

29a. Certifier 29b. Signature and title of certifier

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29c. License number D 3064/

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) September 18 2008

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)
Kamerh Sabapath 201-109 Back River Neck Road Baltimpre Mayland 2121

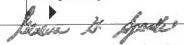
State Registrar

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DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature



ORIGINAL

Jackson

4b. City, Town, or Location of Death

Α.

Year

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2008

4c. County of Death

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Physician

/Medical

Examiner

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Annabelle

4a. Facility Name (If not institution, give street and number)

Physician /Medical Examiner

The law requires that the death certificate be executed burial-transit as signed by page this After

or Attending death. To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the

Division or Vital Records, P.O. Box 68760,

Future Care Nursing Baltimore Home 8. Date of Birth (Month, Day, Year) 1 Year | If Under 24 Hrs Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2**X** F 84 216-12-5296 24 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No MD NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3915 Calloway Ave 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Carr Lowery 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Packer Assembly na Glass Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbert Holmes Martha Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Van Anderson-Son 2019 West North Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 9/30/08 4 Donation 5 Dother (Specify) Woodlawn, Md 22. Name and Address of Facility 21. Sig Vatur of Funeral Service Licenser March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 114FLOMA ULTIPLE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events. Due to for as a consequence of Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 212 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 2 No Hospital: Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🚧 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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SEP 2 9 2008

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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AETOMIN 21209

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2835 32. Registrar's Signature SMITH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** 21/3M Lee Koontz 65 /Medical Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number) 4c. County of Death N/A If Under 24 Hrs. Year 8. Date of Birth (Month, Day Year) 07-17-1923 9. Birthplace (State or Foreign rs. la **85 Funeral** 235-30-4782 1 □ M 2 🕇 F Months Days Min West Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show nit. Pages I and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hyglene. ordant: I fleat 23a or 28a-f show ordant: I fleat 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a "hours is committee man be notified at Rosedale 1 ☐Yes 2 No Completed by Funeral Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21237 1526 Neighbors Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. White 3 Nidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame Mother's Name (First, Middle, Maiden Surname)
Mary Alello 17. Father's Name (First, Middle, Last) Be Frank DePolo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosedale, Maryland 21237 1526 Neighbors Avenue Mrs. Peggy August - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or Gardens of Faith Cemetery 09/29/2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 K es 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical a consequence of): Due to (or **Examiner** SCUD Sequentially list conditions, Examiner Directo (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy 2 No 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification; To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 2313

Registrar's Signature

ORIGINAL

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician Year 10:15 A M 2008 Arlene Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square baltimore Franklin Hospita Kosedale If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖔 F 9/7/1935 Director 73 216-32-0716 Marvland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23a Funeral 1652 French's Avenue 21221 S. A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣No Specify. Specify: ð 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) per nit. Pages 1 and 2 should be filed wit Der artment of Health and Mental Hyglenn Important: If Item 27 is marked other thr any injury or other traumatic event, the 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lawrence Thompson Dorothy Elizabeth Atkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1652 French's Avenue Doris Ray Leach (Husband) Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 9/29 2008 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory Baltimore City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es 50 Cachau 23a. Part1. Enter the disease, or amplication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. 100 Essex, Maryland 21221 Immediate Cause (Final **Physician** Sepsis 15days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine and that initiated events resulting in death) Last Due to (or as a consequence of): burial O. Box 68760, ding physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□ Unknown 9 ☐ Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Kena allu 1∐ Yes 2 No 1 ☐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 8 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPICE 7. Age (In y s. last birthday) Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) **Funeral** Months Hours Min. Davs 1 X M 2 ☐ F Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d, Inside City Limits 10b. County 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantiner must be notified at once. 10a State 1 XYes 2 ☐ No **Funeral Director** more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by 3 M Widowed 4 □ Divorced a 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (duughter) s. Pamela TO. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Son Incest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 0 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima e Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Due to (or as a consequence of): the attending physician IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by the funeral director, page 2 should be 4 Onknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Hospital or Attending Physician: The certificate 5 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Gother (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the within 7 title of certifie 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 76211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 (5. Han 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Lengrand Laura C. EPTEMBER 9:25P 23, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Towson Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min. Months Days Hours 1 □ M 23€ F Director 68 Feb. 19,1940 Maryland 218-36-5814 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, I'm. Medical Exprinter must be neitined at any or other traumatic event, I'm. Medical Exprinter must be neitined at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Directo Baltimore Dundalk Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 7943 Wise Avenue 21222 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes Give 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Matuszewska George A. Zametzer မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Paul R. Lengrand, Jr. 4709 Widdup Court Ellicott City, MD 21043 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Other (Specify) 4 ☐ Donation Baltimore, Maryland Wak Lawn Cemetery 9/27/2008 21. Signature 22. Name and Address of Facility eral S Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD 2122 7922 Wise Ave. Dundalk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC COLON CORCINOMO /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Exami Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 X No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be 1 Yes 250 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nopatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation iours after death. neral Director: Af illed in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 23,2008 DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MARYLAND 21204 32 Registrar's Signature QSLER DRIVE TOWSON. State

DHMH 17 Rev 1/2001

Registrar

SEAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day eptember 19 **Physician** 11:20PM 2008 Mary Frances Langr /Medical 4c. County of Death 4b. City, Town, or Location of Deat 4a. Facility Name (If not institution, give street and number) Examiner HIMOre UNSVI own 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Min. Hours Months Days 1 ☐ M 2 💢 F 80 577-34-3075 July 8,1928 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County show 1 ☐ Yes 2 X No r 28a-f sh notified Howard Director Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or death with USA 9253 West Stayman Drive 21042 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must 3 once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Magdalene E. Schroen Earl Eugene Sizer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ellicott City, MD 21041-0432 Christine Langr (Daughter) P.O. Box 432, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Church Cemetery 9/24/08 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signatur of Funeral Service Licensee 7601 Sandy spring Road Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications the shock, or beart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Ca n e (Final disease or condition resulting in death) ementia **Physician** /Medical Due to (or as a consequence of): Examiner O Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death curtificate be executed within 24 hours after death. burial-transi Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): physician a the burial Physician/Medical ttencing por us as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Day Year Month in the past 12 months 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ Ho 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | DidnRhown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 🗖 certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Beath After t Injury 5 Pending investigation Vitin 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 20 Name and addres. person who comple ed cause of death (Item 23a) (Type, Print) Taiden STONE 711 hoice 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

08-07285 Hong My Lee Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 31025

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 6:05 PM LEVI RYDA 2008 September /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Bultimore Sinai Hospital of Baltimore 8. Date of Birth (Month, Day, Year) 10/28/1915 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 □ M 2 N F Hours Months Days 92 216-46-1857 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examination that be notified at 1 ☐ Yes 2 No Director MD BALTIMORE LUTHERVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 10801 GREENSPRING AVENUE 21093 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELLMAN ALEXANDER HECHT SELMA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 1306 WESTELLEN RD., BALTIMORE, MD SANDRA GERSTUNG/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State CARROLL CREMATION, INC 09/26/2008 HAMPSTEAD, MD 4 □ Donation 5 □ Other (Specify) 21. Signature wuneral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Infarction Myocardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) Tyes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐Yes 2 🗷 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

certificate be execu P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

should be f and Mental I

and !

attending signed by the a d be detached fo certificate has been To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

0

Medical

State Registrar 29b. Signature and title of certifier M.A.

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D59062

29d. Date signed (Month, Day, Year) September 24, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401

Baltimore MA 21215

Hansen 丆. 31. Date filed (Month, Day, Year)

29a. Certifier

SEP 2 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician 18=12 PM 2008 MICHAEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** KOIKLUS BAYVIEW MEDSICAL CENTER BALTIMURE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29,1952 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Months Days Min. 1**⊠** M 2□ F 216-60-9213 Maryland 56 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Dundalk 1 ☐ Yes 2 No Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with United States 21222 48 Shipway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No δ If Yes, Give Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Ital Many Injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Carpenter 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorraine Elizabeth Stein Nicholas James Murphy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7837 Creekshore Way Baltimore, Maryland (Brother) Mr. James Murphy 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/27/2008 Towosn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses Dundalk, Maryland 21222 2 7922 Wise Ave art 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset_and Death Immediate Cause (Final D.44) HY POXIA **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner DISTRESS SYNDREM RESPIRATORY JEVERE MUTE Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed attending physician and for use as the burial-transit BACTERIAL Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the be detached o 9 Unknown ٣. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 🗹 No 1 ☐ Yes 2 ☐ No certificate Physiclan: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Division 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P

State Registrar

DRUCE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4940 5.48.474 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN AVENUE BATTIMURE MD 21224

29c, License number

29d. Date signed (Month, Day, Year)

SEPTEMBER 20, 3008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ()9 27 27 2008 **Physician** Joseph C. Mynar 03:25a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 💢 M 2 🗆 F 218-12-6116 86 11/02/1921 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and if item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, In Warrich Event, In Maryland In the Nortlind and protecting of the traumatic event, In Warrich Event, In Mary or other traumatic event, In Warrich Event, In Mary or other traumatic event, In Maryland Event and In Maryland E 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 □ No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 5117 Eugene Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married XYes 2 Yes, Give 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. Completed by Year or Dates: WII White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Warehouseman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Kohler Joseph Mynar ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5117 Eugene Avenue, Baltimore, MD 21206 Steven Mynar, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/01/2008 Towson, Moryland Hilltop Svc. Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Sanbroad 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 94 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) □Yes 2□No signed by the a o 9 Unknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably cerebrovasc Completed 24b. Were autopsy findings available prior to completion of cause of death? static 24a. Was an has page 2 autopsy performed? Yes 2 100 certificate 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 140 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To he Hospital or Attending Phys in 24 hours after death. he Funeral Director: After this pletely filled in by the funeral dir this 27. Mann eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sentenber 27, 2000

State Registrar

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DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1R50

31. Date filed (Month, Day, Year)

40059540

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HMES MULLEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE CNTR N/A MARYLAND MED If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Dec 1, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours West Virginia 1 X M 2 □ F 1941 66 233-64-7751 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 □Yes ŽXNo MD Ellicott City Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21043 5041 Stone Hill Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **UPS** Division Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Gibson James Roy Mullens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Mullens (Wife) 5041 Stone Hill Drive Ellicott City, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park: 9/29/08 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Simplifie of Funeral Service License Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYCOBACTERIUM TUBERCILLOSIS PERICARDITE Die to (or as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Be Completed Medical Certification: To

Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be exec attending physician for use as the buria Division of Vital Records, P.O. Box 68760. signed by the a has been si e 2 should t certificate ha this c within 24 hours after death

To the Funeral Director:
completely filled in by the

Funeral

Director

28a-f show

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23a

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Examiner rust by notified at

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

and Mental Hygiene. is marked other than

of Health a

Department of Health Important: If item 27 any Injury or other to once.

Physician

/Medical

Baltimore, Maryland 21215-0036

		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 12 Natural Accident 5 Pending investigatio	(Month, Day, Year) Injury Work?	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
	yslcian: To the best of my knowledge, death occurred at the time, date and place, an	

and manner stated

29b. Signature and title of certifie

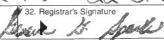
29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) SREENE ST. BALTIMORE EE MA MD

31. Date filed (Month, Day, Year)

SEP 29 2008



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 09 2008 10:20 P M George A. Moore, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Glen Burnie 8 Eastern Street 8. Date of Birth (Month, Day, Year) 04-29-1942 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1**X**XXM 2□ F 66 N.C. 220-40-8882 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 X No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21061 8 Eastern Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ty_Xes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 20 Married 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced 161-165 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chesapeake Woodworking Finisher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Plea Teaque Floyd Decator Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hanover, Maryland 21076 Melissa L. Paugh (Daughter) 3 Leeds Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐ Removal from State MD VET Cemetery Crownsville 9/22/08 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cary L. Kaufman Funeral Home @ MMP, Inc. shac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the most of thing, such as cardiac or respiratory arrest, 21075 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions Due to for as a consequence of than, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ETASI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 A No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 5 Pending

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantiner must be routified at

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

of Health of

Pages

Injury or other Department of Heal Important: If Item 2 any Injury or other

with

Maryland 21215-0036

Baltímore,

P.O. Box 68760

Records,

Division of Vital

burial-transi physician for use as the s been signed by the s page 2

Physician/Medical

<u>\$</u>

Completed

Be

Certification: To

Medical

certificate has funeral director, this After t filled in by the

To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A соmpletely State IF FEMALE: 23b. Was decedent pregnant 9 Unknown

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

and manner sta

investigation

determined

6 ☐ Could not be

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

31. Date filed (Month, Day, SEP 2 9 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2 [] [] 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 1):20 >M **Physician** , 2004 fortember. Cecilia Momongan /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ni Shr MM Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 □ X 608-88-3863 Philippines May 17, 1949 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mydical Ever reset is the multiple and once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2√√ No Director Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 USA 216 Roosevelt Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ՃNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√∑No 2 Specify: 3 Widowed 4 Divorced Filipino Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Clerk Verizon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Jose A. Momongan, Sr Gaudencia Panes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis Fernadez 216 Roosevelt Ave. Glen Burnie, MD 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemeter) crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State Bayview ¢rematory Sept 25, 2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name, and Address of Facility Fink Funeral Home, P.A. 21. Signature of Funeral Service W. eregory Fink M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, o shock, or heart failure. List Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediat Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for se's constiquence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Hospital or Attending Physician; The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 □ No Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) detached Ö 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2**V** No 2 No 1 ☐ Yes Vital funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes Inpatient Division of this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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State Registrar

SEP 2 9 2008

31. Date filed (Month, Day, Year,

ROA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Records, P.O. Box 68760, Division of Vital To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

CT. Latherville, Md 21093

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				ate of Maryland / I			Mental Hygie	ne UUS	3 311	134
			Amend Item: 20b per F. H. 1. Decedent's Name (First, Middle, Last)	1 G-884 10/3/0	Sertificate	or Death	Reg.	. No.	3. Time o	of Death
	Physic	ian	To be at	rdia			Month	Day Yee		00
	/Medi Exami		4a Facility Neme (If not institution, give street	end number)		4b. City, Town, or	Location of Death	4c. County of De	ath	
	Exami	iei	2924 Cherryl	and Rd		Baltin	nore	1///	7	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. lest bit	rthday) If Under 1 Months I	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. B	irthplace (State	or Foreign
	Director		212-42-8487 10M2	NF 65	Yrs.		Jan. 19,	943 We	/ 1	ginia
	and		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		,		10d. Inside C	City Limits
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	r 28a	Director	10e. Street end Number	1 + 20	10f. Zip C		10g	. Citizen of What 0	Country?	
	th with	ai D	2924 Cherr	Vland K	d. 2	1225		US	A	
	ems .	Funeral	11. Merital Status 12. Wa	Decedent Ever in U,S.	13. Was Deceder If Yes, specify	t of Hispenic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indien, nite, etc.	
20	or it	by Fu	1 Never Married 2 Married 1	Yes 2 No Yes, Give	1 ☐ Yes 2 €	/		Specify: "	Lank	
21215-0020	within 72 hours after death with the Maryland ene. than "natural", or flems 23a or 28a-f ahow ha Medical Examiner must be notified at		3 XWidowed 4 ☐ Divorced Ye 15. Decedent's Education	ar or Dates:	. Decedent's Usuel (Occupation	16	b. Kind of Busines	s/Industry	
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yla	should be nd Mental marked c	To I	James McC	ain		Juan	ita	-OWIF	res_	
Baltimore, Maryland	2 4 4 4		19a. Informant's Name/Relationship (Type, Pri	int) 19t	o. Mailing Address (S	Street and Number or Ru	urel Route Number, C	ity or Town, State	, Zip Code) 2	1207
e,	1 and Health em 27 ther tr		20a. Method of Disposition	20b. Place o	of Disposition (Name	of	Date 20	c. Location - City	or Town, State	a
nor	Pages nant of I		1 Burial 2 ☐ Cremation 3 ☐ Remova	al from Statecemete	ry, crematory or othe	er place)		DAL	- 1011	
Ħ	artman prtant: Injury	1	4 Donation 5 Other (Specify) 21. Signature of Funeral Service-Licensee	Lorra		Address of Facility	10/2/08	Dall	Dilla	
Ba	Depa Impo any l		Doronk &	RUDI	Joseph 222	L. Russ	Funeral	Home,	P.A.	6
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the death. Do se on each line.	not enter the mode	of dying, such as cardiac	or respiratory arrest	,	Approxima Interval Be	etween
	Physician								Onset and	Death
N.	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	EMP STAGE	KIDNEY O	SEASE			540	mas
	8. 3	-			consequence of):				2040	24.6
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68760,	ificate be axecuted g physician and as the bunal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c	D00 t0 (0) 63 8	consequence or,				1	
376	ate be nysicia he bu	Icai	Ceuse (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):		and the same of th			
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Вох	ath ce	ian	d						1	
P.0.	Attanding Physician: The law requires that the death certiforate of the state of th	Physician/M	Part II. Other eignificent conditions contributing	ng to death but not resulting i	n the underlying cau	se given in Part I.	100	acco use contribu		
۳.	that the ed by detail	표					1 🗆 Yes	2 2 No 3 □	Probably 4	Unknown
Division of Vital Records,	uires n sign	Completed by					24a. Was an e		b. Were autopsy available prior	findings
S	w red s bee	ojete					performe	a?	completion of of deeth?	
æ	The la ta has	mo					1 ☐ Yes	2 0 No	1 ☐ Yes 2	□No
ita	ian: rtifica ctor, p	Be	25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)			
× ×	hysic his ce	2	1 ☐ Yes 2 ☑ No	1 Inpatient 2 EH/O	• • • • • • • • • • • • • • • • • • • •		lome 5 Resident		pecify)	
n	Ing P	ü	1 Naturel 5 ☐ Pending			. Injury at Work?	28d. Describe how	injury occurred		
8	ttand death tor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	. Place of Injury - At home, fa	M street feetens o	1 ☐ Yes 2 ☐ No	28f. Location (Stre	et and Number or	Rural Route Nu	mber.
<u>></u>	かまずに	Certification:	4 ☐ Homicide determined 200	building, etc. (Specify)	ann, stroot, ractory, t	MILLO	City or Town,			
_	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificata has complataly filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician:	To the best of my knowledge	e, death occurred at	the time, date and place	a, and due to the cau	se(s) and manner	as stated.	(-)
	he Ho in 24 he Fu platat	edicai		n the basis of examination and d manner stated.	nd/or investigation, in	my opinion, death occu				
	To the complex	Σ	29b. Signature and title of certifier		29c. L	icense number		I. Date signed (Mo		
	5		perant moderal	e mo		29296		EPTEMBER		7008
-	P		30. Name and address of person who complete		(Type, Print)	308 Land	VY	Suite 1	. D	21061
100	UNI	To us	31. Date filed (Month, Day, Year)	32. Registrer's Signature	· · · · · · · · · · · · · · · · · · ·	SUS Land	mark Di	C. 116 GI	en burn	neMa
	Sta Registi		SFP 2 9 2008	oz. negistrer s Signature	ask i					j

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a, PII 25, 27, 28a f PerMF, 2884 10/8/08 TT
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MARGARET VIVIAN POOLE 09 22 2008 11:04 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 803 202nd St. Anne Arundel Pasadena 8. Date of Birth (Month, Day, Year) 7/19/1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral Months Hours 1 □ M 2 🔀 F Days 87 215 16 0422 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examination ust by notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 803 202nd St. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: ò 3 ₩ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker <u>General Electric</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Hesterberg ပ Bertha Beach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Jones – daughter 803 202nd St. Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t = 10 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Bayview Crematory 9/24/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility GJ Gonce Funeral Home 21. Signature of Funeral Service Licensee PA 21122 169 Riviera Dr. Pasadena, MD 23a. Part1. Ent - the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Hip Fracture with complications Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner use as the burial-transi Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by malnutrinon 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Retroper 13 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 No Dementia Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 XYes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation subject fell. 8/19/08 unk 1∐Yes 2∐**X**lo 2 XAccident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home 28f. Location (Street and Number of Rural Route Number, City or Town, State) 803 202nd St. 4 ☐ Homicide Pasadena, MD Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar 31. Date filed (Month, Day, Year) SEP 2 9 2008

29b. Signature and title of cortific

6041



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJEKO BUNM!

SMD

To the I within 2

3altimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

29c. License number

0 63726

SUITE

29d. Date signed (Month, Day, Year)

GLEN

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09,23,2008

REM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician Patricia Jane Patterson 2 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Union Memorial Hospital N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🖫 F Director 69 July 22,1939 New York 093-32-4168 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location show filed within 72 hours after death with the Maryla Hygiene.
Hygiene.
viber than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at ent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 7822 Kentley Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify. þ 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years and Mental Hygi Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental William Warren Gertrude Gray ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Unit 1A Baltimore, MD21209 6911 Jones View Drive Mrs. Linda Patterson-Pupo Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/29/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician wee evu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit ei Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Vear 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. of Vital Records, ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation 1 Natural 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ashar tal 10 Registrar's Signature 31. Date filed (Month, Day, Year

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 8 per fh, g889,03/24/09dhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month September 22, 2008 Physician 11:00 PM Helyn A. Pessaro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore St. Joseph Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/21/1907 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 😡 F Maryland 101 Director 213-16**-**3718 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 105 Seminole Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: ≥ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Real Estate Broker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goldie Josephine Schaeffer Samuel David Anderson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Francis Daughter 105 Seminole Avenue; Catonsville, MD 21228 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State 9/26/08 Lorraine Park Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service License Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 401490 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Served arterioselerotic Sie to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit. Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 moved Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

P.O. Box 68760,

law requires that the death certificate be executed s been signed by the s should be detached Division of Vital Records, certificate has page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

1D

State Registrar

Medical

2 ☐ Accident

4 ☐ Homicide

(Check only one)

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

29b. Signature and title of certifier Saurence R. Gellager, us

6 ☐ Could not be

determined

300

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D01786

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aurence

716 Mainer Choice Lane Bactimore Gallager MI 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene

Physic /Medi

Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examination and excitited at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Registr

	T = State Registrar	(Cert	tificate of L	Death		R	eg. No. Z	108	311	J38
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cal	4a. Facility Name (If not institution, give street	and number)	- T	4h City Tours or	Locations		Deptenis			12.332	.7.
ner		and number)		4b. City, Town, or		Deam		4c. County	_		
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	5. Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 1 Year Months Days	If Under :	24 Hrs. Min.	Date of Birth (Month, Day,	Year)	9. Birthpl Coun	ace (State or i	Foreign
	228-50-0927 1 1 M 2	68 Y	rs.	Working Days	riours	IVIII.	12/12/1	939	South	Carol	ina
	Usual Residence of Decedent										
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5		COIU	IIIDT								
Funeral Director	10e. Street and Number			10f. Zip Code			1	0g. Citizen of	What Count	try?	
9	9309 Angelina Circle	2		210	45			U.S.F	4.		
e e	11. Marital Status 12. W	as Decedent Ever in U.S.	13. W	as Decedent of Hi	spanic Orig	gin? (Spe	cify Yes or No-		ce - America		
교		med Forces? □Yes 2□No		Yes, specify Cuba	n, Mexican	i, Puerto I	Rican, etc.)	Bia	ck, White, e	tc.	
Completed by	- C	Yes, Give	1 [∐Yes 2∏No	Specify:			Specif	y: Whi	to	
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Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle, N	1aiden Surnar	ne)		
To E	John Peavy				Ca	roli	ne Holla	adav			
-	19a. Informant's Name/Relationship (Type. Pr	rint) 10h B	Acilina	Address (Street a					Ctata 7in	Codol	
								-		Code)	
	Laura Henkle (Siste			Park Ave			York, N				
	20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Remov	20b. Place of E cemetery,	isposi <i>crema</i>	tion (Name of atory or other place	e) :	Da	ate :	20c. Location	- City or To	wn, State	
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	21. Signature of Funeral Service Licensee	Actuic	22.	Name and Addres	s of Facility	v		TEIL DO	mine,	riat y 1	and
	11.16.11	Δ .	W	Name and Addres	neral		es, Inc	•			
	Moderate 1 100	7		555 Twin					MD_2		
	23a. Part 1. Enter the disease, a complication shock, or heart failure. List only one cau	is that caused the death. Do no se on each line.	t enter	the mode of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between	en
	Immediate Cause (Final disease or condition	MKSBut W.	1.	tnomas	4					Onset and De	ath
	resulting in death)	Dur to (or as a consequence of)		(Montes						1 WIL	
		to (or as a consequence or)	1. 6	C.45	0					CAR	
<u>.</u>	Suquentially list conditions, h	- your or will	1	7 010	w	***************************************			-		
ij	Sequentially not conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of)): •	00						A 1.	6-
am	that initiated events	nerosource		arex					1	6 min	4
Ш.	resulting in death) Last	Due to (or as a consequence of)):								
/Medical Examiner	d										
edi											
Ž	IF FEMALE:	yes, outcome of pregnancy									
	in the past 12 most s?	Live birth 2 Fetal death		Ectopic pregnancy					ite of delive	ry Day Ye	ar
sic	1 □Yes 2 ■No	☐ Pregnant at time of death ☐ Unknown	5 🗆 (Other (specify)				1414	21101	Day 16	ai
Be Completed by Physicial	9 □ Unknown										
Ϋ́	Part II. Other significant conditions contributi	ng to death but not resulting in the	he und	erlying cause give	n in Part I.		23e. Did tob	acco use con	tribute to th	e cause of dea	ath?
Q D	Sporters Docte	I Dertono	e_	>			1 □ Ye	s 2 No	3 Proba	ably 4 □ Un	known
ete	V										
횬							24a. Was at autops	1 24b.	Were autop prior to con	sy findings av npletion of cau	ailable ise of
ŏ							perforn	ned?	death? 1 ∐Yes	2 □ No	
e	25. Was case referred to medical				26. Place	of Death	(Check only on				
	examiner? 1 ☐ Yes 2 █ No Hospita	al: 1 Inpatient 2 ER/Outp	ationt	3 □ DOA Othe	r.		,			HOSP	ICE
Ë		a. Date of Injury 28b. Tin					ne 5 Reside)	
ö	Natural 5 Pending	(Month, Day, Year) Inju		28c. Injury Work			ou. Describe no	w mjury occur	ieu		
cal	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				′es 2□N	40					
ا	4 Homicide determined 286	 Place of Injury - At home, farm building, etc. (Specify) 	ı, stree	t, factory, office		2	8f. Location (St. City or Town	reet and Numl , State)	per or Rural	Route Number	∍r,
Cel		•						,,			
a	29a. Certifier Certifying Physician	: To the best of my knowledge,	death o	occurred at the tim	ne, date an	d place, a	and due to the c	ause(s) and m	anner as st	ated.	
Medical Certification: To	(Check only 2 Medical Examiner: Cone)	on the basis of examination and/ and manner stated.	or inve	stigation, in my op	oinion, deat	th occurre	ed at the time, d	ate and place,	and due to	the cause(s)	
Me	29b. Signature and title of certifier			29c. License	number		2	9d. Date signe	d (Month 1	Dav. Year	
	446			772/	171	_	É) /		1 200	0
į	NAU			1311	IL		6	sepata	2	1200	0
Ì	30, Name and address of person who complete	ed cause of death (Item 23a) (T	pe, Pr	ipt)		_		V	10.2 (10.5)	1	
	HA-UKON 107	00 CASANTO	1	Mr 2	00	C	DZUM.	BA	MD	2104	14
te	31. Date filed (Month, Day, Year)	32. Registrar's Signature						-			-/
ar	SEP 2 9 2008	2 1									
	3FF 6 3 (UUD //)	5 35 12 4 5 6 11525	SEEA.	5							

08-07205 Linda Poland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 31039

		1- For State Registrar	Certificate of	Death		Re	ے کے U ال eg. No.	0 0100.
Physicia	ın/	Decedent's Name (First, Middle,Last)	100 100		11/2 2/4/2011	2. Date of Dear	th Day Year	3. Time of Death
ledical Exami		Linda Marie Poland				Septembe	er 21, 2008	1220 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Elkridge	Location of De	eath	4c. County of De. Howard	ath
		6510 Arrow Way 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Yes	ar If Under 24	Hre 18 Date of Bir	th(MM/DD/YYYY) 9.1	Birtholace (State or
Funeral Director		250-72-2641 _{1 M 2XF}	62 Yrs	Months Day		Min. 03/02	IFor	eign Country) Germany
any.	H	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Locat	ion				10d. Inside City Limits
<u>*</u>	L	MD Montgomery	Kensingt	on				1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	ountry?
the N		2907 Jennings Road		20895			United S	tates
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X		as Decedent of Hi es, specify Cuba		(Specify Yes or No erto Rican, etc.)	14. Race - Am White, etc	erican Indian, Black,
after c	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Yes 2 X No	specify:		Specify:	White
hours		15. Decedent's Education (Specify only highest grade compl	during m	nt's Usual Occupa			16b. Kind of Busines	ss/Industry
36 in 72 l	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		Waitress			Restaur	ant
d with	ē	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle,	Maiden Surname)	
MD 21215-0036 d 2 should be filed within 7 tth and Mental Hygiene. n 27 is marked other than immatic event, the Medica	Be C	Edward V. Hogan			Rosa	Hoffman		
21 ould b d Men s mar		19a. Informant's Name/Relationship (Type, Print)	84.1	-			mber, City or Town, St	
MD id 2 sh lith an in 27 i		Scott O'Donnell, Son					ndria, VA	
nore, MD 21215-0036 ges I and 2 should be filed within 72 nt of Health and Mental Hygiene. E. If item 27 is marked other than 1 other traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 X Cremation 3 X Removal from State	20b. Place of Dispos crematory or ot		·	Date	20c. Location - City	
imo Page ment fant: or oth		4 Donation 5 Other Specify:	Portland				Portland	
Baltimore, permit, Pages I an Department of Her Important: If ite injury or other tr		21. Signature of Ele eral Service Licens MI 111.					neral Serv Burnie, M	
Physician		23a. Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.	e death. Do not enter t	the mode of dying	, such as cardi	ac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	W	Immediate Cause (Final disease a. Acute bron	chopneumon	ia			_	Death
Kaiiiiioi		or condition resulting in death) Due to (or as a consequence of the condition of the condit	uence of):					
	اة ا	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	uence of):		70.01			
	Examine	(Disease or injury that initiated						
led nsit	Exa	events resulting in death) Last Due to (or as a consequence of the con	uence of):					
execu an and	iga	X UNPENDED AMENDED 23a,	27,perME,g	884 10/	22/08 T	T		
760, icate be executed physician and the burial - transit	Medica	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date of deli	very
		23b. Was decedent pregnant in the past 12 months?	2 F	etal death 3	Ectopic pre	egnancy	Month	Day Year
Box (eath ce the attenced for use	Physician	1 Yes 2 No 9 Unknown 9 Unknown	ne of death 5 0	ther (Specify)				Ì
	튄	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause	given in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
P.O.	<u>a</u>					1Ye	es 2 No 3 F	Probably 4 🗹 Unknown
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	Completed by	1		-	-	24a. Was		autopsy findings available
c law e has be 2 sh	ם		-				ormed? death	
tal Recision: The certificate		25. Was case referred to medical		26 Plac	e of Death (Ch		2 No 1 🗸	Yes 2 No
Vital ysician; his certifi director,	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien		Othor:	ursing Home 5	Residence 6 🗸 O	ther: Scene
n of Viding Physi	\vdash	27. Manner of Death 28a. Date of Injury	28b. Time of	injury 28c. Inj	ury at Work?	28d. Describe	how injury occurred	
ion tendir eath.	흹	1 X Natural 5 Pending 2 Accident Investigation	"	1_	Yes 2 No	·		
Division tal or Attendii rs after death. al Director: A	ij	3 Suicide 6 Could not be 28e. Place of Injur	y - At home, farm, stre	et, factory, office	building, etc.	28f. Location (or Town,		Rural Route Number, City
Divis Hospital or At 24 hours after d Funeral Direct	Certification:	4 Homicide determined (Specify)				1	,	
the Hos hin 24 h the Fur	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated,	nowledge, death occunation and/or investiga	irred at the time, on the street at the time, of the street at the stree	date and place, on, death occur	and due to the cau red at the time, date	se(s) and manner as s e and place, and due t	stated. o the cause(s)
vit vit	Me	29b. Signature and title of certifier		29c. Licer	ise number		29d. Date signed (Month, Day, Year)
4.		wellen ,	17)	0.0	.M.E.		September 22	, 2008
014		30. Name and address of person who completed cause of dea					 	
0 1		Russell Alexander MD. Assistant Medica		1 Penn Stree	t, Baltimore	, MD 21201		
St Regist	_	31. Date filed (Month, Day, Year) 32. Registrar's	Acres Acres and the second	100			OCME	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🖰 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10:0B **Physician** September 24, 2008 SANDRA LEE QUINN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1413 Old Ocean City Road Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yeer) 2/27/1958 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗷 F 50 213 78 5374 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show sny injury or other traumatic event, the Medical Examiner must be institted at 1 ☐ Yes 2 No 1413 Old Ocean City Rd, Salisbury Director MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1413 Old Ocean City Rd 21804 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2K No Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mars Supermarkets 10 Produce Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Martin A. Ouinn Betty O. Mortzfelt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21804 19a. Informant's Name/Relationship (Type, Print) 1413 Old Ocean City Rd Salisbury, James Quinn - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9/29/08 Baltimore, MD 22. Name and Address of Facility GJ Gonce Funeral Home, I 169 Riviera Dr. Pasadena, MD 21122 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OP Physician CANCIZA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Incas a preservence of Examiner To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ENO 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 ₽₩0 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 00058416 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O BUX 1733 SATISBURY WD 21802 COASTAL 6 Hurminany

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 9 2008

GOBALL

32. Registrar's Signature

08-07181 Latonia Ross

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 3 104 | State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar			(Certific	cate of	Death					Reg. No.				
Physicia	ın/	1. Decedent's Name		e,Last)				-				Date of De Month	Day	Year		3. Time of	
Medical Exami	ner	Latonia	Ross							, i		Septemb	er 20,	2008		1315	nrs
		4a. Facility Name (if		n, give street and r	number)		41	City, To		ocation of	Death		40	c. County o	Death		
		Bon Secours	s Hospital					Baltimo									
Funeral		Social Security Nu	umber	6. Sex	7. Age (In y	rs. last bi	irthday)	If Under Months	1 Year Days	If Under	Min.	8. Date of E	sirth(MM	/DD/YYYY)	Foreign	place (St	ate or
Director		220-86-0494		1 M 2xx F		37	Yrs.	Wichtins	Days	110015		July 2	8, 19	971	Cour	ntry) 1	1 D
		Usual Residence of														10d Incid	e City Limits
, any		10a. State 1	10b. County		10c.	City, Tow	n or Location	n Balti	movo								s 2 No
and show	5	rib															3 2 110
ie Maryland or 28a-f show fied at once	Director	10e. Street and Num						10f. Zip C					10g. Cit	izen of Wh		ry?	
the Na or		1920 East 3	Oth Str	eet					2121					USA			
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status		A more or al	ecedent Ever Forces?	in U.S.	13. Was	Decedent s, specify	of Hisp	anic Orig	in? (Spec	cify Yes or Nican, etc.)	lo-	14. Race White		an Indian	, Black,
death or ite	Ĕ	1 X Never Marrie		1 Yes	2 X	No			_			, , ,			Ol actr		
after al", o	by F	3 Widowed		orced If Yes, Give Y				Yes 2					1.01	Specify: I		In contrast of	
nours natur	귷	15. Decedent's Edi				d) 16a	a. Decedent during mo	's Usual O st of worki	ccupations of life.	on (Give F DO NOT	aind of wor use retired	rk done d)	166.	Kind of Bu	siness/in	dustry	
6 1,721 an ", ical B	Completed	Elementary/Secor	ndary (0-12)	College	(1-4 or 5+)		CI	pervi:	Or				1 9	Gallo			
5-0036 lled within 7 Hygiene. I other than	Ē		Elect Maletella	l and				per vi		8 Mother	s Name (I	First, Middle	Maide				
15-(filed Hyg d oth		17. Father's Name (Howard	Ross					- 1	O. IVIOTI ICI		Lydia A					
2121 and be fil Mental F marked c event,	o Be	19a. Informant's Nar				1	19b. Mailing	Address	(Street	and Num		•		-	n, State,	Zip Code)
MD 2 d 2 shou lth and h n 27 is n	٩	Crystal Ho										timore,					
_ = 6 = 2		20a. Method of Disp	position				e of Disposi		of cem	etery,		Date	20c	. Location -	City or T	Town, Sta	te
Ore ges 1 t of H ither		1 XXBunial 2	Cremation	3 Removal	from State		natory or oth ty Ceme				10/0	2/2008	Ba	1timore	. Mai	rvlano	i
altimore, rmit. Pages I a ppartment of He pportant: If ite		4 Donation 5 21. Signature of Fur	Other Sp	ecify:			•	-	ddress	of Facility		lie Fur	- 1		-		
Bal Depar Impo		21. Signature of Full	eral Service	0								Baltimo				1217	
	-	23a. Part I. Enter the	e disease, or	complications that	t caused the c	leath. Do										Approx	mate Interval
Physician /Medical		failure. List onl	ly one cause	on each line.												Betwee	en Onset and Death
xaminer		Immediate Cause (I			s a consequer		olic Carui	JVascon	פוט וג								
		Composition list con	nditions	b.													
	je	Sequentially list cor if any, leading to im	nmediate	Due to (or a	s a consequer	nce of):											
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760, ficate be executed g physician and the burial - transit	led	IF FEMALE:		23c If ve	s, outcome of	pregnan	CV			_			2	3d. Date of	delivery		
876 tifica ng ph	In/M	23b. Was decedent				p9	₂ Fe	tal death	3	Ectopi	c pregnan	ісу	- 1	Month	D	ay	Year
Box 68 death certif the attending	icis	1 Yes 2 N	,		egnant at time	of death	pro-	ner (Spec									
1 of Vital Records, P.O. Box 68' ling Physician: The law requires that the death certifiant. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physician			9 011	known		ltia - ia tha c	and orbitan		ives in Pr	ort I	23e Di	tobacc	o use conti	ibute to t	the cause	of death?
.O. hat the	by F	Part II. Other signi			g to death but	not resu	iting in the t	ingenying	lause y	iveninira	art i.						✓ Unknown
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Ceco	Completed												s 2	No 1	✓ Ye	s	2 No
of Vital Records, ng Physician: The law requir Ner this certificate has been s meral director, page 2 should	Be C	25. Was case refer	red to medica					2			(Check o	nly one)					
Vita nysici this c	0	examiner?	2 No	Hospital: 1	Inpatient		VOutpatient		<u> </u>	Other ₄		Home 5		dence 6	Other	:	
of ng Pl After unera	l :i	27. Manner of Deat	th	28a. Da (Mo	ate of Injury onth, Day, Year)	28	Bb. Time of I	njury 2		y at Worl		28d. Descri	oe how i	njury occur	red		
ion tendi tor:	g;	1 Natural 2 Accident	5 Pen	etigation						es 2							
Division tal or Attendi as after death.	Certification	3 Suicide	6 Cou	ld not be 28e. P	lace of Injury	- At home	e, farm, stre	et, factory,	office b	uilding, e	tc.		n (Stree n, State)		er or Ru	ral Route	Number, City
Di pital ours a	leg.	4 Homicide		rmined (Spec													
e Hos e Fur etely		29a. Certifier (Check only	Certifying P	hysician: To the aminer:On the bas	best of my kno	owledge,	death occu	red at the	time, da	ite and pl	ace, and o	due to the c	ause(s) ate and i	and manne	r as state due to th	ed. e cause(s	3)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after feath. To the Funeral Directed: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical			and manne	er stated.	uvii aliu/	or myesuya			e number		uu, u		d. Date sigi			
	Σ	29b Signature and	title of certific	er /	111			290	O.C.					eptembe			, 501/
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n		30. Name and addr						111 D	nn Ci	reet P	altimor	e, MD 21	201				
7		Patricia Aro			istant Med		ammer	111 P6	1111 SI	icel, D	aiumore	5, IVIL) Z I	201				
S Regis	tate	31. Date filed (Mon	SEP Z	2008	Registrar's S	griature	Selection of the select	2000									
					- Charles Charles	-	ORIGINA										
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			1 - For Amend Item Later Registrar 1. Decedent's Name (First, Middle, Last)	25 per dr.,	g883_0	9/29/08dh tificate of	Death	2. Date of Dea	ath	3. Time o	0 4 2
	Physici		Frances A. Ritter					Month 09	21	08 10:50	0 м
	/Medio		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death		4c. County o		
			WMHS-BRADDOCK CAMPU	S		CUMBERI			ALLEGA		
	Funeral Director		5. Social Security Number 220-26-9648 Usual Residence of Decedent	7. Age (In yrs. 76	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Apr 9,	y, Year)	9. Birthplace (State Country) Maryland	or Foreign
	/land		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside C	City Limits
	Mar)	icto	MD Allegany		Cumbe	rland				1 □Yes	s 2 No
	h with the 23a or 28 st be not	al Director	10e. Street and Number 218 Humbird Street	A		10f. Zip Code	21502		10g. Citizen of Wi		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evertinar must be neithed at once.	by Funeral	1 Never Married 2 Married 1	/as Decedent Ever in U rmed Forces? ☐Yes 2KINo Yes, Give		Was Decedent of H If Yes, specify Cuba 1 □Yes 2X No	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race Black Specify:	- American Indian, , White, etc. white	
Š	hours tural"	d be	3 ☑ Widowed 4 ☐ Divorced Ÿ	ear or Dates:	162 Dece	dent's Usual Occup	etion		16b. Kind of Bus		
יל רב ר:	within 72 iene. • than "na	Completed	(Specify only highest grade con		(Give life. I	kind of work done of DO NOT use retired	during most of work	ing	own ho		
Maryland 21215-0036	uld be filed Aental Hyg rked other Iic event, I	To Be C	17. Father's Name (First, Middle, Last) John Stotler					e (First, Middle, zel Car	Maiden Surname		
Mary	nd 2 shou alth and N 27 is mai er traumai	_	19a. Informant's Name/Relationship (Type. P Patrick Ritter/son	rint)	1	ng Address (Street Nathan (-	State, Zip Code) 740	
Baltimore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Remove 4 ☒ Donation 5 ☐ Other (Specify)	val from State	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date	20c. Location - C	City or Town, State	
Balti	permit. Departri Importa any Inju	1 1	21. Signatur coneral Service Linsee	irector		Name and Addre ate Anato	-		Baltimo	re Street	
	Physician		23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one car Immediate Cause (Final	ns that caused the dealuse on each line.	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a		Approxima Interval Be Onset and	etween
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consec				O. 77		200	
	ruted d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):						
68/60,	tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a consec	quence of):						
P.O. Box 68	eath certi attending for use a	Physician/Medi	in the past 12 months?	yes, outcome of pregn Live birth 2 Feta Pregnant at time of Unknown	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		23d. Date Mon	of delivery th Day	Year
as, r.	w requires that the disconnections that the disconnection is the detached should be detached	5	Part II. Other significant conditions contribu	ting to death but not res	sulting in the u	nderlying cause giv	en in Part I.			bute to the cause of	
Vital Records,	ne law requestable has been ge 2 shoul	Completed						24a. Was autoj perfo	psy pr prmed? de	/ere autopsy finding rior to completion of eath?	s available cause of
<u>o</u>	Physician: The la r this certificate ha ral director, page 2		25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		Yes 2 No	
>	/sicla s cert direct	o Be	examiner? 1 Yes 2 No Hospit	tal: 1 / Inpatient 2	T FR/Outnatier	nt 3 🗆 DOA Oth	OF:		dence 6 ☐Othe	r (Specify)	
DIVISION OF	ttending Phydeath. stor: After thi	ation: T		Ba. Date of Injury (Month, Day, Year)	28b. Time o	f 28c. Injur Wor	y at		how injury occurre		
DIVIS	al or Attend s after death al Director: ed in by the f	Certification: To	3 Suicide 6 Could not be determined 28	Be. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rural Route Nu	mber,
	To the Hospital or within 24 hours after To the Funeral Directory is a completely filled in b	Medical (29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner:								(s)
)	Voith Com	M	29b. Signature and title of certifier	W		29c. Licens	3 3 7 I			(Month, Day, Year)	
			30. Name and address of person who comple Dr. Gamar Zamar	, 904 Sel	ton Dr		umberla	nd H	arylano	1 2150.	2
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature			,	ı		
DHN	1H 17 Rev 1/2	_	SEP 2 9 2008	flower.	13. P						
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		State	aryland / Dep		lealth and M	lental Hygie	-	31043
Physici		Registrar Decedent's Name (First, Middle, Last) Donald Walter Rockwood		Timoate or i		Date of Death Month	Day Year 22,2008	3. Time of Death 4:45 A
/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 5126 Durham Road West	e (In yrs. last birthday 54 ^{Yrs.}	Colum	Location of Death	8. Date of Birth (Month, Day, Y May 23,1	4c. County of Death Howard 9. Birt Co	
p	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Howard	10c. City, Town or L	mbia			g. Citizen of What Co	10d. Inside City Limits 1
be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, if a Medical Examination to rolling a	by Funeral Dir	10e. Street and Number 5126 Durham Road West 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 10e. Street and Number 12. Was Decedent Armed Forces? 1 □ Yes 2 □ 1 Yes, Give Year or Dates:	Ever in U.S. 13.	10f. Zip Code 21 . Was Decedent of H If Yes, specify Cuba 1 □ Yes 2√2 No	1044 lispanic Origin? (Spean, Mexican, Puerto Specify:		U.S.A. 14. Race - Ame Black, White	rican Indian,
d within 72 hour gjene. er than "natural", tre Malicel E.	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5 5+	(Give life.	edent's Usual Occup e kind of work done o DO NOT use retired tware Engi	during most of worki d) ineer	ng	Private Corporat	Industry Commerical
permit. Pages 1 and 2 should be filed within 7 bearment of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumantic event, it a Mana once.	To Be (17. Father's Name (First, Middle, Last) Alan Paul Rockwood	40. 10.		18. Mother's Name	Goodell		Zin Codo)
t and 2 sh Health and Item 27 is n		19a. Informant's Name/Relationship (Type. Print) Ellen L. Dally (Wife) 20a. Method of Disposition	5126	Durham Ro	d./West Co	olumbia,	City or Town, State, 2 MD 21044 Oc. Location - City or	
mit. Pages partment of portant: If i y Injury or		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Columbia	Memorial 22. Name and Addre	Pk. 9-29-		Clarksvill	e, MD
2 8 2 E 8		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	i the death. Do not ei	nter the mode of dyir	KNOLLS RO	oad_Colu	mbia, MD	21045 Approximate Interval Between Onset and Death
Physician /Medical Examiner		resulting in death)	a consequence of):	CA	NORR			
sician and surial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as	a consequence of):					
eath certificate be exattending physician after use as the burial-	n/Medic	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant			-		23d. Date of de	livery
at the death by the atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		B ☐ Ectopic pregnance □ Other (specify) _	ey		Month	Day Year
The law requires that the death certificate are has been signed by the attending phys age 2 should be detached for use as the	by	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did toba		o the cause of death? robably 4 Unknown
sician: The law r certificate has be rector, page 2 sh	Completed					24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Physician: The la	To Be		ent 2 ER/Outpati		ner: 4 \sum Nursing Ho	h (Check only one, ome 5 Resider 28d. Describe how	nce 6 ☐ Other (Spe	ecify)
the the	Certification:		ny, Year) Injury ury - At home, farm, s	Wor M 1□	k? Yes 2∐No	28f. Location (Stre	eet and Number or R	ural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, de	ath occurred at the ti	ime, date and place,	and due to the ca	use(s) and manner a	is stated.
To the Ke within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner st 29b. Signature and title of certifier		29c. Licens			d. Date signed (Mon	
o _i		30. Name and address of person who completed cause of c	_		05 797 Valfe	BACTIN	1/22/2	008 4D 21231
Sta Registi			rar's Signature		voite	p to little	200 211	, 2 2 Z
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** illian Kosner 0230 AM September 19 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Harbor Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2**X**XF Director 215.22.1008 81 JAN 11, 1927 IOWA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes ½ No Director ANNE ARUNDEL LINTHICUM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 108 NURSERY RD. 21090 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SUPERVISOR **GARMENT** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER STEFFEN 2 ELISE MULLLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) APRIL L. MOSKIE NIECE 108 NURSERY RD., LINTHICUM, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Kurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) GLEN HAVEN CEMETERY SEP. 23,2008 GLEN BURNIE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility FINK FUNERAL HOME, P.A. GREGORY FINK M01148 426 CRAIN HWY, S. , CLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure). List in one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heart /Medical Due to as a consequence of): Examiner anoxic encephalgat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

3

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 2 9 20

MD

2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stacey A. Trotter MD, 3001 South Hanover Street, Baltimore, MD 21225

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-001

29d. Date signed (Month, Day, Year)

			1- State of Maryland / Per dr., g	883 of the Certificate of I	lealth and Mer dinb D <i>eath</i>	ntal Hygien Reg. N	2008	31045
	Dhyaiai		1. Decedent's Name (First, Middle, Last)		2.	Date of Death Month D	ay Year	3. Time of Death 6:33p.
-	Physici /Medic		Hugh Joseph Pinkney Sinclai				22, 2008	0:33 D "
	Examin	er	4a. Facility Name (If not institution, give street and number) Brightwood Genesis Nursing Home	Luther	Location of Death		c. County of Deat Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi		MILE Jan Od Han La		9. Birti	hplace (State or Foreign
П	Director		220-20-0119 ¹™ ²□F 79	Yrs.	Ja	Month, Day, Yea	129 Mary	ritand
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Location				10d. Inside City Limits
	a-fsh	ctor	Md. Baltimore Luthe	rville				1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number	10f. Zip Code 21093		10g. C	Citizen of What Co	
	s 23a	Funeral	8 Deep Run Road 11 Marital Status 12, Was Decedent Ever in U.S.		ienanic Origin? (Specify	Ves or No-	14. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eyzin tractional be multiple at once.	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑No	n, Mexican, Puerto Ric	an, etc.)	Black, White	e, etc.
2-0	72 ho 'natur	Completed by	15. Decedent's Education 16a (Specify only highest grade completed)	a. Decedent's Usual Occup (Give kind of work done of	during most of working	16b. 	Kind of Business/	Industry
121	within ene. than "	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	\life. DO NOT use retired Inventor	()	Iı	nventing	
<u>5</u>	filed I Hygi other ent, II	BeCc	17. Father's Name (First, Middle, Last)		18. Mother's Name (F	irst, Middle, Maide	en Surname)	_
<u>Iar</u>	uld be Menta arked atic ev	10 B	Hugh Joseph Sinclair		Bertha	Freedom		
, Mar	und 2 sho alth and 27 is ma er trauma			b. Mailing Address <i>(Street i</i> L11 West 28th				
Baltimore, Maryland	Pages 1 a sent of He nt: If item ry or othe		d David O Comption 2 Demonstrate State cemeter	of Disposition (Name of ery, crematory or other plac op Service Co			Location - City or Towson,	
Balti	permit. Departm Importa any inju		21. Signature of Fuheral Service Ucensee	22. Name and Addres	ss of Facility n Funeral h	dome. Inc		ork Road
			23a. Part 1. Enter the disease or complications that caused the death. Do shock, or heart failure. List only one cause on each line.				1000001	Approximate Interval Between
day	Physician		Immediate Cause (Final disease or condition Cholmyil	corcino:	mu			Onset and Death
	/Medical Examiner		Due to (or as a consequence	of):				
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60,	icate be executed physician and s the burial-transit	E	resulting in death) Last Due to (or as a consequence	7 W/SIS				
58760,	ficate physi s the b	dical	d	[00 103 .]				
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnanc 5 Other (specify) _	у		23d. Date of del Month	ivery Day Year
	s that gned b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause give	en in Part I.			the cause of death?
ord	equire een sig oould b					1 🗌 Yes	2 No 3 P	robably 4 Unknown
Division of Vital Records,	: The law I cate has b page 2 sh	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐1	prior to death?	utopsy findings available completion of cause of
Zit	sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Oth	26. Place of Death (C		с По# <i>(</i> 0	-74.1
o	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injur	y at 280	I. Describe how in		спу)
ion	ending sath. or: Aft he fun	atio	1 ☐ Natural 5 ☐ Pending (Month, Ďay, Year) 2 ☐ Accident investigation		Yes 2□No			
Divis	al or Att s after de il Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, f building, etc. (Specify)	arm, street, factory, office	28f.	Location (Street City or Town, Sta		ural Route Number,
	n 24 hour n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.					
	To the withing the complex com	M	29b. Signature and title of certifier	29c. Licens	2749	290	2/23/2008	h, Day, Year)
7	INTI		30. Name and address of person who completed cause of death (Item 23a)		1/100			1
	0	•	31. Date filed (Month, Day, Year)		VE, TOW!	in, h	12 3/3	ca Co
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Stonature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 24, 2008 SEILER DORIS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore St. Joseph Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 ☐ X F 19, 216-09-9490 93 Dec. 1914 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show r 28a-f show notified at 1 ☐ Yes 2X No Director Ellicott City Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or items 23a or the Medical Examiner must be 21043 USA 3020 N. Ridge Road permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiena. Important: If item 27 Is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: ģ 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Smith Thomas B. McGee ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3416 Rollingview Court; Ellicott City, MD 21042 Paul M. Seiler Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 9/29/08 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. mo1050 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dartre Mon **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Quality (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 PNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ANO 2 -NO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

19c. License number

29d. Date signed (Month, Day, Year)

19c. License number

29d. Date signed (Month, Day, Year)

19c. License number

19d. Date signed (Month, Day, Year)

19d. Date signed (Month, Day, Year) TRRI SULYE B

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician Stokes 09 2008 7:10p. Florence 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Nursing Home Catonsville Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2√2 F **217-12-**0868 Director 30 09 98 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21207 1107 Mirga Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 2 **X** No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: ğ Specify: Black X□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, In a M House Homemaker 9th grade 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burley Lee ೭ Junius Street 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Phyllis Delaney-Daughter 1107 Mirga Circle, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State Arbutus Memorial Park 9/30/08 Arbutus, Md 4 □ Ponation 5 □ Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21. Sign 21215 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed the aftending physician and hed for use as the burial-transit Exami Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown cate has been s , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed?

1 Yes 2 XNo certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE REISTERSTOWN 210 Ima 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ai yiaiiu /	_	tificate of		u Weritai my	Glen Reg. N	21111	8 31048
	Physicia	an	1. Decedent's Name (First, Middle, La MARIA	SOF1	A				2. Date of De Month	ath - Z	ay Yea	
- Shape	/Medic Examin		4a. Facility Name (If not institution, gi		71		4b. City, Town, o	r Location of De			c. County of De	
			JOHNS HOPKI.	US BAYU	IEW .	cen.	BA	LTIM				
	Funeral Director		212-32-8792	Sex 7. Age 1 □ M 2 □ F	96	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Date of 3 – 4 – 1	th ly, <i>Yeal</i> 9 1 2	9. E N e	Birthplace (State or Foreign Country) W York
	rland		Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, To	own or Lo	cation					10d. Inside City Limits
	a-f sh	ctor	MD		Balt	imo:	re					1 XYes 2 □ No
	3a or 26	al Director	10e. Street and Number 318 S. High S	treet			10f. Zip Code 212	02			citizen of What	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event har must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		1	Nas Decedent of H fYes, specify Cuba I □Yes 2 1 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	-	14. Race - Al Black, WI Specify: W	
21215-0036	n 72 ho "natur odicell	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Occup kind of work done OO NOT use retired	during most of v	working	16b.	Kind of Busines	ss/Industry
212	d withingiene.	Juno:	Elementary/Secondary (0-12) 8th	College (1-4or 5	+)		mstress	-)		Jc	seph :	S. Bank
	uld be filed Aental Hy, rked othe tic event,	To Be C	17. Father's Name (First, Middle, Las Vincenzo Geno						Name (First, Middle Presci		,	
, Maryland	: 1 and 2 should Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship Anna M. Brotta	(Type. Print) dau	ghter!	19b. Mailin	ng Address (Street	and Number or	Rural Route Numb	er, City	or Town, State	a, Zip Code) 202
Baltimore,	Pages 1 and the substitute of the sunt: If item surt or other sury or ot		20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Special	Removal from State	20b. Place ceme	e of Dispo etery, cren	sition (Name of natory or other place Park	ce)	Date 9/2008	20c.	Location - City	or Town, State
Balti	permit. Departri Importa any Inju		21. Signature of Funeral Service Lice		1 2023	22	. Name and Addre	ss of Facility	Joseph N	. Z	annin	o Jr. _F H ,MD 21224
1	Physician	Å e	shock, or hear fallure. Ust only Immediate Cau e (Final disease or condition	pplications that caused one cause on each lin	the death. D	o not ent	er the mode of dyi	ng, such as can	diac or respiratory a		2111020	Approximate Interval Between Onset and Death
y.	/Medical Examiner	er	resulting in death) See in the property list of th	b. Due to (or as			y Et	EMA				24 hours
o,	tificate be executed g physician and as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequen	ce of):						
68760,	cate be	edical		d								
O. Box	Attending Physician: The law requires that the death certific roteath. crosed. After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3	□Ectopic pregnanc □Other <i>(specify)</i> _	у			23d. Date of Month	delivery Day Year
S, P.	ss that gned b	by Pł	Part II. Other significant conditions	contributing to death be	ut not resultin	g in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	e to the cause of death?
ord	w require been sign should b	ted I							_ 1□	Yes	2 No 3	Probably 4 Onknown
Vital Record	: The law cate has b	Completed	100						24a. Was auto perfo 1 □Yes		prior death	autopsy findings available to completion of cause of 1? 'es 2 □ No
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			oth SELDOA Oth	er.	Death (Check only			
	nding Physician: th, After this certifical funeral director, p	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		Outpatier b. Time of Injury	IL 3 LI DOA	y at	g Home 5 Res		<u>`</u>	Specify)
Division of	or Attendi after death, Director: A in by the fu	Certification: T	2 Accident investigation 3 Suicide 6 Could not to determined	e 290 Place of Init	ury - At home c. (Specify)	, farm, str	M 1 = eet, factory, office	Yes 2□No	28f. Location (City or To			Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		(Check only 2 Medical Exa	hysician: To the best miner: On the basis o								
)	o the vithin 2 o the l	Medical	29b. Signature and title of certifier	and manner sta	ited.		29c. Licens	se number		29d. E	Date signed (M	onth, Pay, Year)
	->-0		ALSod 1	MEDICAL	DOCT	on	RE	5001			09/2	6/08
			30. Name and address of person who Patrick SAF	completed cause of d	eath (Item 23	la) (Type,	N Aven	14c B	ALTIMO	NE	MD	21224
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 20	Registra	ar's Signature	Ass	N.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

				For State Registrar	Otate of Mary	ylaria / D	Certificate of	Death		Reg. No. 2	108	31010
	1	Physicia	an .	1. Decedent's Name (First, Middle, I					2. Date of De Month SEPTEM	BER ^{Day} 25,	2008	3. Filmel of Death? J
		/Medic Examin	al	ANN 4a. Facility Name (If not institution, g	STUDNITZ ive street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death	J.10A
	1	LXaiiiii	i d	LEVINDALE HEB			BALTII		D. Data of Bin	***	N/A	lace (State or Foreign
		Funeral Director		216-10-3027	Sex 7. Age (I	In yrs. last birt	Months Days	Hours Min.	8. Date of Bir (Month, Da 06/03/	1912	9. Birthp Cour	CANADA
		Aaryland f show ed at	or	Usual Residence of Decedent	LTIMORE 10	0c. City, Town	or Location REISTERSTOW	N			1	0d. Inside City Limits 1 □Yes X□No
		with the Na or 28a- t be notifi	Funeral Director	10e. Street and Number 10 SUNDAY COUR	Т		10f. Zip Code	21136		10g. Citizen of	What Cour	ntry?
*	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cubi 1 □ Yes 2td No	lispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. Rad Bla Specil	ce - Americ ck, White, y: WH]	etc.
	Maryland 21215-0036	ithin 72 ho ne. nan "natul e Medical	Completed	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of wor d)	king	16b. Kind of B	NMEN'I	
5	121	filed w Hygier ther th int, the	Co	12 17. Father's Name (<i>First, Middle, La</i>	est)		SECRETAR	18. Mother's Nan	ne (First, Middle			MARYLAND
Anr	lan	lid be fental fental rked o	To Be	SAMUEL		SPECTOR		SOPHI			AMON	
.1		ind 2 shoualth and M 27 Is mai		19a. Informant's Name/Relationship DEBORAH LETBOV	(Type. Print) VITZ / DAUGHT	TER 19b.	Mailing Address (Street SUNDAY COU	and Number or Ru RT REIS	Iral Route Numb	per, City or Town $^{ m N}$, MD $^{ m 21}$, State, Zip 136	Code)
1,72	Baltimore,	Pages 1 a nent of Hei nt: If Item iry or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 3 p4 □ Dpnation 5 □ Other (Spe		20b. Place of cemeter CHEVRA	Disposition (Name of ry, crematory or other pla AHAVAS CHE		Date 26/ 2008	20c. Location RANDAI		
Studnit	Balti	permit. Departm Importa any inju		21. Shipmare of Funeral Service Li	nsee		22. Name and Address 8900 REIS	ال		NSON & E PIKESVII	ROS.	INC. D 21208
な	l*			23a Part1. Enter the disease, or conshock, or heart failure. List or	ny one cause on each line.			ng, such as cardiae	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death
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	ds, P.	uires that the signed by detaction	d by Ph	Part II. Other significant condition Demen Lec	s contributing to death but	not resulting in	the underlying cause gi	ven in Part I.		tobacco use col		the cause of death?
	Division or Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/N						24a. Was auto perf 1∐ Yes	s an 24b opsy ormed?	. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
	/ital	cian: 'ertifica	Be C	25. Was case referred to medical examiner?	Hospital:		LOH.	hor	ath Check onl	one		
	0	g Physi er this eral dir	n: To	1 ☐ Yes 2 2 No 27. Marmer of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b.	intropatient 3 DOA Time of njury 28c. Injury	4 Layursing I		how injury occu		ify)
	visior	Attendin or death. ector: Aff by the fun	Certification: To	1 Alatural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion	/ - At home, fa]Yes 2□No	28f. Location City or To	(Street and Nun	nber or Rui	ral Route Number,
	Ö	oital or urs afte eral Dir	Cert		Physician: To the best of		a death occurred at the t	imo date and plac	1		nanner as	stated
		To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying 2 Medical E	xaminer: On the basis of e	examination ar	nd/or investigation, in my	opinion, death occ	curred at the time	e, date and place	e, and due	to the cause(s)
		To the Complete Compl	Ž	29b. Signature and title of certifier	my 1		29c. Licen	se number 3		29d. Date sign	ed (Month)	Day, Year)
		16		30. Name, and address of person w	ho completed cause of dea	ith (Item 23a)	(Type, Print)	1,		0 110	10	~ ~ <i>U</i>
		Sta	ato	31. Date filed (Month, Pay, Year)	32. Registrar	's Signature	(Type, Print) LEVINCE	ill				
		Regist		SEP 2 9 20	UD Steers.	Si A	DEMIL					

DHMH 17 Rev 1/2001

SHATZ Potient brown as Mikhall Baltimore Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

	Registrar		Cer	tificate of	Dealli	Reg	J. No. 200	8 31050
Physician	Decedent's Name (First, Middle, Last MIKHAIL	SHATZ				2. Date of Death Month	Day Year	3. Time of Death 8 1102 AM
/Medical Examiner 4a.	Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	Septemb	ev 25, 200 4c. County of Dea	
•	Sinai Hospital of			Baltimon	e City		N/A	
Director	Social Security Number 220-37-4088 Sual Residence of Decedent	xX	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/18/19	9. Bir 926	thplace (State or Foreign ountry) MOLDOVA
0	a. State 10b. County	TIMORE 10c. City	, Town or Loc	eation BALTIMOR	Ε			10d. Inside City Limits 1 □Yes ※□No
th with the Mar 23a or 28a-f si 18t be notified ral Director	e. Street and Number 108 NELSON ROAD			10f. Zip Code	21208	100	g. Citizen of What Co USA	ountry?
al", or ite	. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba □Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
ed within 72 hou ygiene. ner than "natura" t, the Medical E	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give I life. E	ent's Usual Occup kind of work done OO NOT use retired CTRICIAN	during most of work	ing 16	Sb. Kind of Business.	•
Ibe filed wental Hygie ed other the event, the	'. Father's Name (First, Middle, Last)	SHATZ	ELE	CIRICIAN	18. Mother's Name	e (First, Middle, Ma	GOVERNMEN aiden Surname) VODOVO	
nd 2 should I alth and Men 27 is marke r traumatic	Pa. Informant's Name/Relationship (7)	ype. Print)		g Address (Street NELSON RO	and Number or Rur	al Route Number,	City or Town, State, MD 21208	
Pages 1 annent of Hee ann: If Item Lay or othe	a. Method of Disposition 1X Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	nemoval from State DAT	lace of Disposemetery, crem	sition (Name of eatory or other place HEBREW	CEM. 9/26		Oc. Location - City or	
permit. Department importation once.	Signature of Funeral Service License	see		Name and Addre	ss of Facility SO TERSTOWN	L LEVINSO	ON & BROS. KESVILLE,	., INC. MD 21208
Physician dis	3a. Part1. Enter the disease, or comp shock, or heart failure. List only o mediate Cause (Final sease or condition sulting in death)	lications that caused the death ne cause on each line. a. 5-5-6-6 Gue Due to (or as a consequence)	د	er the mode of dyir				Approximate Interval Between Onset and Death 24 h
Examiner Se if a	equentially list conditions, any, leading to immediate uuse. E.iter Underlying auto (Disease or injury at initiated events	b. New Out to Or as a consequ	ence of):					10 days
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rtifica ng ph as th Aedi	SSIME	d. Cononary au	itery o	directe				
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w requires that we require that should be detailed by Place by Pla	rt II. Other significant conditions co	ntributing to death but not resu			en in Part I.			o the cause of death?
	biabeter mellitu		-			24a. Was an autopsy performe 1 □ Yes 2	prior to	utopsy findings available completion of cause of
Physician: This certificated director, and d	i. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Oth		n (Check only one)		
	. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Work	y at	28d. Describe how	ce 6 Other (Sperinjury occurred	эспу)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be C	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre		Yes 2□No	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
o the Hospit ithin 24 hours o the Funera ompletely fille	Da. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	vsician: To the best of my know iner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the tirestigation, in my co	me, date and place, pinion, death occur	and due to the car red at the time, dat	use(s) and manner a e and place, and du	e to the cause(s)
29 A WHAT THE PROPERTY OF THE	b. Signature and title of certifier			29c. Licens	e number		d. Date signed (Mon	
	Danalaun,				- 000		September	25, 2008
\ 30.	Name and address of person who co	ompleted cause of death (Item	23a) (Type, F	rint)	l al Ba	ltimar		
State State Registrar	SEP 2 9 2008	2. Registrar's Signati	ure		of sa	- THE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5, perFH, G884, 10/21/08, WS
State of Maryland / Department of Health and Mental Hygiene
amend #5 Per FH G883 9/30/208 III

Beg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month 03-20 AM **Physician FRANCES SPENCE** SEPTEMBEL 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None SINAI BALTIMORE CITY 6174 HOSPITAL BALTIMORE 8. Date of Birth Month, Day, Year) March 18,1955 9. Birthplace (State or Foreign 5. Social Security Number **218–17–7637** 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Ireland 53 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at YYes 2 □ No Director Maryland None Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 Ireland 2506 Pickwick Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) A \(\text{N} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 □Yes 2XXNo KUTH JPEN(E Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mentage. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physical Therapist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Spence Estella Kelly ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Spence Sister 8 Lower Churchtown Road Churchtown Dublin 14 Ireland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State Deans Grange Cemetery Oct 6,2008 Dublin, Ireland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell Wiedefeld Funeral Home Inc junature of Funeral Stryic Lice 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 days Corebra Vascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transi P B that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial Box 68760, Physician/Medical nding p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No o been signed by the should be detached 9 H Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ Dk 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division To the Hospital or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of celtifier SEPTEMBER 26, 2008 00063322 erson who completed cause of death (Item 23a) (Type, Print) 10 30. Name and ordress of INA 32. Registrar's Signature BRAS Registrar

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24a, Was an autopsy and production and production autopsy aut	
performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No
U 25. Was case referred to medical examiner? Hospital: 157 Inpution 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
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27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury of Injury M 1	Number or Rural Route Number,
25. Was case referred to medical examiner? 1	nd manner as stated. lace, and due to the cause(s)
1/84827065 09	signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. REZA ZAHIRI D.O. 22 S. GREENE ST. BALTIMURE MD	
State Registrar SEP 2 9 2008 32. Registrar's Signature	21201

DHMH 17 Rev 1/2001

Examiner **Funeral** Director the Maryland "natural", or Items 23a or 28a-f show idless Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 ir than "natur of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Manage of the f of Health Department of I Important: If Ite any Injury or of once.

Physician

/Medical

Funeral Director

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Completed

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Physician /Medical **Examiner**

Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit attending p certificate has been signed by the rector, page 2 should be detached ours after death.

eral Director: After this certific filled in by the funeral director, I within 24 hours at To the Funeral C completely filled To the

Division of Vital Records, P.O. Box 68760,

9-27-2008 METRO CREMATORY 21. Signature of Funeral Service Licenses Immediate Cause (Final disease or condition resulting in death) MASSIVE ULMONARY EMBOULS Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform METABOLIC 2 □ No 1 Ves 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number D 66 335 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 W. BATIMORE ST

1100 AM MINNIE REED 22,2008 SEPTEMBER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BON SECOURS HOSPITAZ BAZTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 K Months Days Hours 216-24-37 80 2-5-1928 SC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 □ No MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3204 CARLISLE AVENUE 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. Specify: 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **BCPS** 4 TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES ARTHUR MARY CROMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3204 CARLISLE AVENUE BALTIMORE, MD 21216 LLOYD WHITE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Houes

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Day

24b. Were autopsy findings available prior to completion of cause of

2 No

Year

Month

3. Time of Death

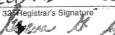
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

SHEINGELD MD

BALTIMORE

State Registrar 31. Date filed (Month, Day, Year) SEP 2 9 2008



Funer

Direct

	1 - For State Registrar		Department of F Certificate of		Re	g. No.	8 3105
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er	4a. Facility Name (If not institution, give street and	ŕ		r Location of Death		4c. County of De	
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	12 17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name		Own Home	
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P	19a. Informant's Name/Relationship (Type. Print)	19	9b. Mailing Address (Street				te, Zip Code)
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08-07247

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

st Wright		State of Maryland / Department of Health and Merital Hyglerie - For State Certificate of Death Reg. No. 2
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year OQ54 bre
cal Examir		Ernest Wright September 23, 2008
		4a. Facility Name (if not institution, give street and number) Hatrbor Hospital Center 4b. City, Town, or Location of Death 4c. County or Death 4c. County or Death
Funeral		5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		237-78-6016 1 M 2 F 59 Yrs. Months Days Hours Min. 10-7-1948 N.C.
ķ		Usual Residence of Decedent 10a. State
ow any	- 1	MD N/A Baltimore
Maryland 28a-f show d at once.	홠	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
or 28	Director	2827 Hollins Ferry Road 21230 U.S.A
with the Maryland ms 23a or 28a-f sho		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
leath r	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 No No. Mexican, Puerto Rican, etc.) White, etc.
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be notified at once	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: Black
led within 72 hours after Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
2 = 12	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade N/A Welder Allied Chemical
uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	E -	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
be filec ntal Hy rked of	Be C	Ernest Wright Lettie Daniels
ould be fil Mental F marked c event, f		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 she th and 27 is umat		Latanya Wright-Wife 2827 Hollins Ferry Balto, MD 21230
Theal Fiten Fiten	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pages 1 and 2 shoul nent of Health and M ant: If item 27 is n or other traumatic		4 Donation 5 Other Specify: Carver Park 9-29-2008 Murireesboro, N.C
permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H
	k	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva
hysician /Medical		failure. List only one cause on each line.
xaminer		Immediate Cause (Final disease a Blunt force head trauma or condition resulting in death) Due to (or as a consequence of):
		h
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	Cause Enter Underlyin, Cause (Disease or injury that initiated Due to (or as a consequence of):
vecuted n and rtransit	Ä	events resulting in death). Last
te be exect ysician an burial - tr	<u>8</u>	Xunpended X AMENDED 20a, per Fh 23a,PII 27,28a-f, perME, g885 11/3/08 TT
ate be	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
In a factor of the factor of the description of the factor of the factor. Done of the factor of the factor. The law requires that the death certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the b	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
e atten	Sic	1 Yes 2 No 9 Unknown 9 Unknown
that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
res tha signed be det	d by	Hypertensive atherosclerotic cardiovascular disease 1 Yes 2 ✓ No 3 Probably 4 Unknown
w requir	Completed	24a. Was an 24b. Were autopsy findings availab autopsy prior to completion of cause of
ie law le has ge 2 sl	E D	
ysician: The l his certificate b director, page	ပိ	25. Was case referred to medical 26.Place of Death (Check only one)
hysicial this cer 1 direct	B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other:
ding Ph n. After ti funeral	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 26c. Injury at Work? 28d. Describe how injury occurred
tendir eath. Ior: A	ţi	Natural 5 Pending 9/23/08 Fnd 9:13 Am Yes 2 X No Subject fell
pital or At ours after d eral Direct filled in by	ific	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Rumber) - At home, farm, street, factory, office building, etc. 28f. Location (Street and Rumber) - At home, farm, street, factory, office building, etc. 28f. Location (Street and Rumber) - At home, farm, street, factory, office building, etc. 28f. Location (Street and Rumber) - At home, farm, street, factory, office building, etc. 28f. Location (Street and Rumber) - At home, farm, street, factory, office building, etc. 28f. Location (Street and Rumber) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, office building, etc. 28f. Location (Street) - At home, farm, street, factory, etc. 28f. Location (Street) - At home, farm, street, factory, etc. 28f. Location (Street) - At home, farm, s
prital ours a filled	Certification:	4 Homicide determined (Specify) Alley Baltimore, MD
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To th within To th comp	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	2	296. Signature and title of certifier O.C.M.E. September 24, 2008
		ma S / 1
F)		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S	tate	
Regis	trar	\$27.2 9 2008 Come
MH 17 Rev 1/2	2001	ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

1. Decedent's Name (First, Middle, Last) 2. Date of Death Williams Day Physician Month AINIA 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Balto 4c. County of Death Examiner N/A Augsburg Lutheran Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year) 6-5-1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🕱 F 85 216-14-4660 VA Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits 10b. County 1√2 Yes 2 □ No N/A Director MD Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other trainment. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 24☐ No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) National Can Co. 12th grade Assembly Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Mackey Vergie Goodman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Traiten-Niece 2466 TerraFirma Road Balto, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Description | 2 □ Cremation | 3 □ Removal from State | 4 □ Donation | 5 □ Other (Specify) King Memorial Pk 10-2-2008 Randallstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** leav! /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♣No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home ည 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 Tyes death. Director: 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours a 162 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. September 25,2008 **15 Tibell** D31513 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maw st. 21136 MD 25 7 bell MÞ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State	of Mary		epartmer				-	•	000		01055
			Registrar 1. Decedent's Name (First, Middle, Last)						rtificate of Death 2. Date of Deat				Reg. No. 3. Time of Death			
	Physicia		Mary Walch						Month			Month	Day Year		M	
-	/Medio		4a. Facility Name (If not		ive street and n	umber)	arrena	4b. City,	Town, or	Location	of Death	Sept 16	1	c. County of De	eath	7:48 A
	LAUIIII	CI	Stella MAris					T.						D-11.		
	Funeral		Social Security Number		Sex	7. Age (/	In yrs. last birtl	day) If Unde	onium r 1 Year	If Under		8. Date of Bir (Month, Da	th	Baltimor 9.E	Birthplace	e (State or Foreign
	Director		096-03-0069		1 □ M 2√√√ F	9	95 Y	rs. Months	Days	Hours	Min.	April			Country)	PA
	pu ,		Usual Residence of Dece				- 01 T						, ,		Tana	1-11-01-11-11
	aryla shov	5	10a. State 10b.	County		10	0c. City, Town	or Location								Inside City Limits
	he M	Director		assau			Rocky	ille Cent					10 0	*** - * * * * * * * * * * * * * * * * *		
	with t		10e. Street and Number						p Code				10g. C	itizen of What	Country	
E	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Madeal Examinar is ust be neithed at	Funeral	63 Argyle Plac	ce	12. Was Dec	andont Eva	r in II C		11570	ionopio Or	iain? /Cn	ecify Yes or No		USA 14. Race - Ar	morioon	Indian
. u	ter d	핊	11. Marital Status 1 ☐ Never Married 2	2 ☐ Married	Armed F	orces?	1111 0.3.	If Yes, spe	cify Cuba	in, Mexical	n, Puerto	Rican, etc.)	-	Black, Wi		indian,
:48	urs af	<u>Ş</u>	3∰Widowed 4□		If Yes, G Year or	aive		1 ☐ Yes	2 XXX	Specify:	•			Specify:	Mb	ite
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Z S	ould be Mental larked o	မ	John Peter L	awless							lary E	llen Duf	fy			
16, Maryl	2 should and Mei is marke raumatic		19a. Informant's Name/F	Relationship	(Type. Print)		19b.	Mailing Address	s (Street a	and Numb	er or Rur	al Route Numb	er, City	or Town, State	e, Zip Co	ode)
e, ER	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Wickel Examiner traust be truffled at		Joseph J. Wals		SON		39	05_Clover	hill	Rd, Ba			2121			-
SEPTEMBER Baltimore, I	Pages 'nent of I		20a. Method of Disposition 1 XXBurial 2 ☐ Cree		()Removal from	State	cemetery	Disposition (Na crematory or o	me or other plac	e)		Date	20c. l.	ocation - City	or rown,	, State
E E			4 □ Donation 5 □				Cemeter	y of the			Sept	19, 200	8 W	estbury,	NY	
SEI	permit. Departr importa any Inju		21. Signature of Funeral	96900	Clark.	3001110		22. Name a	Funer	a 1 Hon	ie, P.	Α.				
			23a. Part 1. Enter the dis	0 5		MO1148						n Burnie		21061	Δτ	proximate
		8 16	shock, or heart faile Immediate Cause (Final	ure. List only	one cause on	each line.	dean. Bom	t enter the mo	ac or ayırı	g, such as	cardiac	or respiratory a	11631,		Int	terval Between nset and Death
	Physician /Medical		disease or condition resulting in death)		· · · · · · · · · · · · · · · · · · ·			ACCIDE	NT						-	
	Examiner			- 1	Due ic	O (OI as a CI	onsequence of):								
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0.	e exe ian ar irial-t		resulting in death) Last		Due to	(or as a co	onsequence of):								
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Вох	eath certific attending p for use as	an/	23b. Was decedent preg in the past 12 month			birth 2	Fetal death	3 ☐ Ectopic	pregnancy	y				23d. Date of o	delivery Da	y Year
Ö	the a	Physician/Me	1 ☐ Yes 2 X No 9 ☐ Unknown		4 ☐ Pre		ne of death	5 Other (s	pecify)	<u> </u>				MOITE	Da	y real
σ.	that the de ned by the a detached		Part II. Other significant	conditions	contributing to	death hut n	ot resulting in	he underlying o	rausa nive	en in Part I		23e Did t	obacco	use contribute	to the c	ause of death?
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WA	itcian; The law certificate has rector, page 2 s	m l										24a. Was autoj		prior t	autopsy to compl ?	findings available etion of cause of
	, 30 <u>cr</u>		OF Man ones referred to	man all and l								1 □ Yes	2 X N	o 1 □ Y	es 2[□No
MARY of Vital	Physician; r this certific ral director,	Be c	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	medicai	Hospital:	11	0 🗆 50/0	patient 3 □ De	Othe			(Check only o		• T		HOODTOE
	g Phy er this eral o	Ĕ	27. Manner of Death			of Injury onth, Day, Ye			28c. Injury Work	4 🗆 N		me 5 ∐ Resi 28d. Describe i		6XOther (S	pecity)	HOSPICE
Ö	Attending r death. ector: After by the funer	atio	1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending investigation		nth, Day, Ye	ear) Inj	ury M		<br Yes 2 🗍	No					
Division	ar deg recto	iji iji	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not to determined	28e. Plac	e of Injury	- At home, farr	n, street, factor	y, office			28f. Location (Street a	nd Number or	Rural R	oute Number,
Ö	tal or rs after ai Dii	Certification: To	4 E Homoldo		Duik	anig, etc. (t	орсону)				*	City of You	vii, Glai	.6)		
	Hospi 24 hou Funer tely fil	ical	29a. Certifier (Check only 2	Certifying P Medical Exa	hysician: To the miner: On the	e best of m basis of ex	ny knowledge, amination and	death occurred or investigation	at the tir	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and manner nd place, and d	as state	ed. e cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one) 29b. Signature and vitle o		and ma	nner stated			c. License					ate signed (Mo		
	F≥Fŏ					12). (1		1	52	70	0		202-0	1	1/m2008
			30. Name and address of	person who	completed car	ISP of death	(Item 23a) /T	vne Print)	1)		(حــــ	CHI MILL	ten	v and
	12		DR. ERNEST				V9 II	VALLE	y RD	тт	момт	UM, MD	2100	93		
	Sta	te	31. Date filed (Month, Da			Registrar's								- -		
	Registra	ar	CED 2	2008	200	. 1.	To Land	als I								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Wade Jr. 9:25a.™ 09 2008 Thomas 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice
Social Security Number | 6. Sex | 7. A If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours **№** M 2 F Yrs 216-54-4483 19 49 MD 59 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No Director Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 5343 Cordelia Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married If Yes, Give Year or Dates: 1 ☐ Yes 🏋 ☐ No Specify. þ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk 12th grade MD Metrics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geraldine Hall Thomas Wade Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 5343 Cordelia Ave, Bal; timore, Md Vera Wade-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/24/08 Woodlawn, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non small years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of). Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Day Ye ar 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> cance 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 **N**0 6 DOther (Specify) HOSpice Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Medical

Records, P.O. Box 68760 Division of Vital Physician: Thomas To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

al Hygiene. other than "natural", or items 23a or 28a-f shov vent, the Medical Examinat must be notified at

Item 27

± 5

Physician

/Medical

Examiner

physician and sthe burial-transit

the attending phone

his certificate has been signed by the director, page 2 should be detached

this

After

death.

funeral

Important: If any Injury o once.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D51788 9-23-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 620 Boulton St. Bel Air MD MD JIM 32. Registrar's Signature 31. Date filed (Month, Day, Year) **ORIGINAL**

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 38A M **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF MARYLAND BALTIMORE CNTR MED If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days 1 □ M 2 X F 0877271931 178-24-9962 77 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Addial Exercity to a public any once. 1 XYes 2 □ No Director PA York Hanover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 217 Willow Street 17331 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No White Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Service Book Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel A. Epley O. Laurence Deatrick ပ 19b. Mailing Address (Street and Number or Rural-Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard A. Weaver, Husband 217 Willow Street, Hanover, PA 17331 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 109/27/2008 Hanover, Pennsylvania 4 ☐ Donation 5 ☐ pther (Specify) M01113 22. Name and Address of Facility Panebaker Funeral Home Service Licensee 311 Broadway, Hanover, PA 17331 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEMORRHAGE DAY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DA GASTROINTESTINAL BLEEDING if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine O AGULLOPATH that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 PNEWMONIF 2 XNo 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**Vo 1 ☐ Yes 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, signed by the attending I be detached for use as Division of Vital Records, s peen s

To the Hospital or Attending Physician:

pr

death.

Baltimore, Maryland 21215-0036

anding physician and use as the burial-transi certificate has b director, After this funeral

ours after death. within 24 hours a To the Funeral I

29a. Certifier (Check only one)

BALTIMOG

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MID

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2008

BECNADETTE 31. Date filed (Month, Day, Year)

32. Registrar's Signature

STATON, MD

22 SIGREENE STI

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year WATSON THELMA 2=40 PM /Medical 09 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Hospital Good Samaritan Britismore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 1 □ M 2 □ F 84 Director 220-<u>22-6770</u> 28,1924 May Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examinating it is not filed at anones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6101 Loch Raven Blvd Apt. Funeral 21239 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 ☑ No Specify. Specify: Black **3**○Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Clerk Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Santee Person Bessie Butts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Mayo (sister) E. Shadow Lawn Drive, Neptune, N.J.07753 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GarrisonForestVetCemOct.1,2008OwingsMills,MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Sep515 resulting in death) /Medical Due to (or as a consequence of): Examiner United Tract Injection
Due to (or as Konse wence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the buriant-transit Advanced Stage of Ling Concer Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 TONo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

21 Cm

Medical

Cill 31. Date filed (Month, Day, Year) SEP 29 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NID

and manner stated.



16 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES 000

Baltimore

29d. Date signed (Month, Day, Year)

21209

09/25/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Clyde Irvin Yates September 23, 2008 1:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6665 Pirch Way Elkridge Howard 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) Funeral Days Months Hours Min. 67 Director 215-38-3162 1941 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6665 Pirch Way 21075 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 65-66 Year or Dates: 1 ☐ Yes 2 【 No Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver TWI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Edgar Murray Yates Theresa Talbott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Yates- wife 6665 Pirch Way, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Cemetery 9/26/2008 Brentwood, Maryland 22. Name and Address of Facility Fleck Funeral Home, 21. Signature of Funeral Service Licensee INC. M0123 Mylu 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Rectal Cancer Years /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Lung Disease 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Valvular Heart Disease 24a. Was an autopsy performed? 1□ Yes 2▲INo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No မ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manuer of Deam 1 X Natural 2 Accident 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Box 68760, nding physician use as the buria Division or Vital Records, P.O. this

Baltimore, Maryland 21215-0036

Medical

within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral within 24 hours a To the Funeral I

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela Duncan MD , 7350 Van Dusen Rd., Ste 130, Laurel, MD 20707

and manner stated

31. Date filed (Month, Day, Year) State SEP 29 2008 Registrar

4 Homicide

29a, Certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 04.00 PM SEP Thomas 15 2008 Robert Young /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOS PITAL SAINT AGNES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M☐M 2☐F 228-68-7257 59 Wash. DC Director 01-29-1949 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6200 Ducketts Lane 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 190 If Yes, Give Year or Dates: 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🗷 Married 1969 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: 3 Widowed 4 Divorced 1971 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ins. M. 10 Exhibit Contractor Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Willis P Helen Margaret Kidd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia G. Young - wife 6200 Ducketts Lane, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-19-08 Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility Gary L. Kaufman Funeral Home at f Funeral Service Lie 21. Signatu M00053 a MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** INTRACEREBRAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) g physicial and Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached f 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page 2 performe certificate 1 ☐ Yes 2

No 2 **N**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Division To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes death. 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) P22004 SEPTEMBER 15, 2008 MD

DHMH 17 Rev 1/2001

State Registrar ANUSHA IYER, ST AGNES HOSPITAL, 900 S.C. ATON AVE, BALTIMORE, MOZIZZA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month **Physician** 10UNGER 2:00 PM WILLIAM 09 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BURNIE MAPLEDALE ANNE GLEN 8. Date of Birth (Month, Day, Year) June 19, 1935 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 **X**M 2 □ F Months 212-32-6146 MD 73 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Directo Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 USA 46 Mapledale Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes. Give Specify. Specify: Completed by 3 √Widowed 4 □ Divorced White Year or Dates er than "natur 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Route Tech Service America 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ဂ Alice Holland Charles W. Younger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 202 Belvedere Ave, Glen Burnie, MD 21061 Debbie Hampe Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Sept 23, 2008 Glen Burnie, MD 21. Signayr 1) uneral Service Licensee 22. Name and Address of Facility P.A. x. Grebty FORTU 426 Crain Hwy S., Glen Burnie, MD 21061 MUITED Approximate Interval Between Onset and Death Part 1. Enter the diseas or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. ist only one lause on each line. 23a, Part 1 Immediate use (Final disease or co dition resulting in de III) Physician YO CARDIAL MINUTES /Medical Due to (or as a consequence of): Examiner ZYRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) o 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HYPER CHOLESTEROLEMIA 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

thours after death.

uneral Director Afely filled in by the fur within 24 hours a

To the Funeral I

completely filled To the Hospita

State

Registrar

Medical

D58914

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MADISON PARK DRIVE GLEN BURNIE MD 21061 1417 32. Registrar's Signature

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician MARIE BALDWIN AUTH SEPTEMBER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPTIAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Months Days Hours Director 94 220-42-5703 May 8, 1914 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show 1 ☐Yes 2 X No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7407 Willow Road, Completed by Funeral USA Apt 350 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: 3 ☐ Widowed 4 ื Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event." National Institutes Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary of Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည George E. Baldwin Emily French 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James F. Auth 12627 Fingerboard Road, Monrovia, Maryland 21770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 ☐Other (Specify) Metropolitan Crematory 9/13/2008 Alexandria, Virginia 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of pineral Service Licensee 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or tion resulting in death) inglete Physician day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ disease (orona 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2008 D 54616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 944 BUKI 310 Street W 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 5 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 6 50 PHYLLIS ELIZABETH LOVE BOSTON 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 17124 Queen Victoria Ct,#301 MONTGOMERY Gaithersburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 21, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 74 Maryland <u>216-30-3806</u> Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Experiment must be notified at Director 1 XYes 2 ☐ No MD Pr. Geo Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1207 Minnesota Way 20774 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2X No Specify ₫ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12th Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked othany Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Love Ida Mae Hackett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Gopee (Daughter) 1207 Minnesota Way, Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)
Signature of Funeral Service Livens Ardent Crematory 9/12/08 Hanover, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 14 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCUD disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 Hospital: Niece's Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 NOther (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 Tyes 2 🗆 No 2 ☐ Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DMG mo 29018 9/12/3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Drive, Silver SPring, MD 20902 Betsy Ballard, M.D. 31. Date filed (Month, Day, Year) 3. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 15 2008

Box 68760. P.O. Division of Vital Records,

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Min. 1 M 2 F Months Davs Hours 010-28-4916 73 Director JULY 7,1935 MASSACHUSETTS Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No other traumatic event, the Madical Examiner must be notified Funeral Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 125 BAY DRIVE 21666 UNITED STATES 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Completed by Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KASSON B. WHEELER DOROTHY A. ALWIS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NONA FAY CARON/SISTER 2290 WICKLEY AVE., STOW, OHIO 44224 permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of CHESAPLER, LYCREMATION CENTER 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State SEPT.18,2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter 1 disprise, or complication shock, or heart an ure. List only one ca is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Dres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☐ No 1 ☐ Yes 2. - No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation eral Director: A 1 TYes 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 10 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, D Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

DHMH 17 Rev 1/2001

	-	For State of Maryland State Registrar		tificate of L			g. No. 200	8 3106		
Physicia	n	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death 5:30 P. M			
/Medica	al .	Johnnifred E. Brow 4a. Facility Name (If not institution, give street and number)	4h City Town or	Location of Death	Septembe	4c. County of Death				
Examine	er	1603 Robert Lewis Avenue			far1boro		Prince G			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign country)		
Director		577-60-5372 1□M 2 X F 97	Yrs.	World Days	Tiours Iviin.	Sept. 1,	1911 Nor	th Carolina		
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	ation				10d. Inside City Limits		
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and 2 alth a		Thelma Saunders Tinsley	12706	Prince1	eigh Stre	et;Upper	Marlboro	,Maryland		
of He		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Dispos netery, cren	sition (Name of natory or other plac	e) Sent	Date . 10,2008	20c. Location - City	or Town, State		
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permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trau		21. Signature of Fundyal Service Lipensee	> R	Name and Addres	ton Compa	ny Morti	cians, In	IC.		
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/Medical		resulting in death) Due to (or as a consequence of):								
Examiner	<u></u>	Sequentially list conditions, Due to (or as a consequence of):								
ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injuly that initiated events c.								
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Ital or as after all Dir	Certification:	4 ☐ Homicide determined building, etc. (Specify)				July of Town	., σιαιο)			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.								
To the within 2 To the complet	Med	29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date signed (Mo	onth, Day, Year)		
•				D00	59182		September	8,2008		
•		30. Name and address of person who controlled cause of death (Item :								
		Gerren S. Perry, M.D.; 3450 For	rt Mea	de Road;	Suite 10	9; Laure	el, Maryla	and 20724		
Sta Registr		31. Date filed (Month, Day, Year) 32. Restrar's Signatu	JE A	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** September 11, 2008 Morna Allyn Berdit /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 5174 Phantom Court Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months 1956 Michigan Director 276-46-5524 March 1 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. The Medical Eventual and Injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Columbia Howard 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 21044 5174 Phantom Court USA Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 →No Specify: þ Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clinical Psychologist Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Berdit Lilyan Deitz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5174 Phantom Ct. Columbia, MD 21044 Lilyan D. Berdit/mother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 09/13/08 Beltsville, MD 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the o sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final Rul **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Electronic Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 201 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 □Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: ₽ investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 29c. License number

(S) 03

State Registrar 31. Date filed (Month, Day, Year)

32. Raistrar's Signature

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

Registrar's Signature

Hanovar

		State of Maryland / 1 - State Registrar	-	rtment of H tificate of D		lental Hy	giene Reg. No.	2008	31069	3		
Dharaini		1. Decedent's Name (First, Middle, Last)				2. Date of De		Year o	3. Time of Death			
Physicia Medic/		Janice Waunda Buell September 2008 3:15 A M										
Examin	er	4a. Facility Name (If not institution, give street and number)	County of Death 1timore									
		Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthdav)	Timonium If Under 1 Year	If Under 24 Hrs.	8. Date of Bi			lace (State or Foreign	n		
uneral irector		544-32-4153 1□M 2\(\text{\M}\)F 78		Months Days	Hours Min.	8. Date of Bir (Month, Di Jan 13	3, Year)	30 Orego	try)			
		Usual Residence of Decedent		-11					Od. Inside City Limits			
shov	ō	10a. State 10b. County 10c. City, Tow		auon					1 □ Yes 2 📉 No	- 1		
28a-1	Director	MD Anne Arundel Fort Me	eade	10f. Zip Code			10g. Citiz	zen of What Count	try?			
3a or		7234-D Johnson Court		20755			USA					
ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No	D- 1	14. Race - America Black, White, e				
or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 □Yes 2∑ No Specify:					Specify: White				
tural"		3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a	16a. Decedent's Usual Occupation			16h		MITE and of Business/Ind	_			
n "na Vedic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)									
er tha	E O	Hor	ne He	ealthcare	Attenda	nt	Hea	lthcare				
d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle	, Maiden			`		
narke	٩	Albert Bredleau	N- 8 # - 11 (Agnes and Number or Rui	rat Clauda Mumi	- City	Town Ctata Zin	(unk)			
n 27 is r ner traur		Virginia DesFosses/daughter 72	2 34- I) Johnson	Ct. Ft.	Meade,	MD :	20755				
Department or need and wenter rayeries. In particular, or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be multipled at once.				ition (Name of atory or other place • Cremato	e) ory 09/1	Date 5/08		cation - City or To sville, I				
y physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Find the final transfer for the final transfer f										
within 24 hours are beau. To the Funetal Director. After this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day Yea					
n signed Ild be det	d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause								n		
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After thi	<u> </u>		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Input at Work?				4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSP t 28d. Describe how injury occurred s 2 ☐ No					
al Director ed in by the	Certification	2 Deviside 6 Dequid not be	28e. Place of Injury - At home, farm, stre			28f. Location City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ne Funera	edical (29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge of the basis of examination and manner stated.										
To tl	Me	29b. Signature and title of certifier		29c Licens	e number		29d. Da	te signed (Month,	Day, Year)			
12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093										
Sta Registi		31. Date filed (Month, Day, Year) SEP 16 2008 32. Projectar's Signature		•								
		DR. TARTO MAHMOOD 2300 DULANEY V. 31. Date filed (Month, Day, Year) 32. Signature	ALLE	Y RD. T	IMONIUM,	MD 2109	93					

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed

JANICE BUELL Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland

SEPTEMBER 11, 2008 3:15 a.m. Baltimore, Maryland 21215-0036

				ype or Print in				-	•) .	
			_ FOI	State of Maryl	-			Mental Hygi	ene	0 21070	
			State Registrar		Cei	rtificate of	Death		J. No. 4 U U	0 31070	
	Physici	an	1. Decedent's Name (First, Middle, Last)	CLARY				2. Date of Death SEPT.	Day 3 20	3. Time of Death 5:00 AM	
	/Medic		4a. Facility Name (If not institution, give si	Caller		4h City Town o	or Location of Death		13, 20 4c. County of D	0	
- Barrell	Examin	er	Montgomery General I			Olne			_	gomery	
	Funeral		Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 22)	Year) 9.	Birthplace (State or Foreign Country)	
	Director		213-12-1801	^{M 2□ F} 86	Yrs.			Jan. 22,	, 1922 W	ashington, DC	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits	
	Mary a-f sh	tor	Maryland Montgo	mery	Silver	Spring				1 ∐Yes 2 X No	
	th the	Director	10e. Street and Number		·	10f. Zip Code			g. Citizen of What	Country?	
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show offeel Examinar mast be notified at		11611 Amherst Av			20902			JSA		
	er deg	Funeral	11. Waltar States	2. Was Decedent Ever i	n U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.	
336	ırs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced	1 XXYes 2 □ No If Yes, Give Year or Dates: WWI	-	1 □Yes 2 K No	Specify:		Specify:	White	
21215-0036	"natura	ted	15. Decedent's Education (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	pation during most of work	Autor or	6b. Kind of Busine		
21		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	, l	Naval Ord Laborato:		
	be filed withii ntal Hygiene. Id other than event, Il e M		17. Father's Name (First, Middle, Last)	2	Fiece	.r.car ie		ne (First, Middle, Ma			
Maryland		o Be	Joseph Clark					izabeth N	,		
aryl	s 1 and 2 should be to the theath and Mental them 27 Is marked other traumatic eve	ᅀ	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street	l t and Number or Ru	ral Route Number,	City or Town, Sta	te, Zip Code)	
Ž,	and 2 satth a 127 is		Carol M. Andre/Dau	ıghter	2904	Shamrock	Terrace,	Olney, N	MD 20832		
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20 amoval from State	b. Place of Dispo cemetery, crer	osition (Name of matory or other pla	ser Ser	Date 20	Dc. Location - City	or Town, State	
ij	Pag tment tant: I		4 □ Donation 5 □ Other (Specify)	S		s Cemete	ry	2008		pring,Maryland	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.		21. Signature of Funeral Service Licenses					Funeral			
			23a. Part 1. Enter the disease, or complic	ations that caused the	· · · · · · · · · · · · · · · · · · ·					ing, MD 20901 Approximate Interval Between	
	Physician	i y	shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.		12				Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a con		disease	e				
	Examiner		Sequentially list conditions b.	Roetal	Heedie	4					
U.	pe sit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):	0					
D	be executed ician and burial-transit	xam	that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):						
760,				Dementi	' '						
687	tificate ig physi as the l	ledic	0.								
Вох	death certificate e attending physi d for use as the t	hysician/Medical	23D. Was deceder pregnant	ic. If yes, outcome of pro		☐ Ectopic pregnan	cv		23d. Date of	•	
O. E	ne dea the at hed fo	sici	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant at time 9 ☐ Unknown		Other (specify)			Month	Day Year	
σ.	hat the	Ф	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute							te to the cause of death?	
Vital Records,	w requires t s been signe should be o	Completed by	Case Imethis.	Exterior	214	,			1 ☐ Yes 2 ☐ No 3 ☐ Pro		
CO	law req as beer 2 shou	lete		U				24a. Was an	24b. Wer	re autopsy findings available	
Re	e la	omp						autopsy	ed? prior	r to completion of cause of	
ital	ician: The certificate ector, pag	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 th (Check only one)	•	res 2 🗆 No	
of V	S =	examiner? Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (5)									
	ing Affel unei		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea	28b. Time o Injury	Wo	iry at rk?]Yes 2 □ No	28d. Describe how	28d. Describe how injury occurred		
Division	il or Attending I after death. Director: After d in by the funer	rtification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, str		Jies Z JNO	28f. Location (Stre	eet and Number o	or Rural Route Number,	
Ö	lor A after Dire	ertii	4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	pecify)	,,		City or Town,			

attending p cate has been signed by the page 2 should be detached Completed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page Be Certification: To

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

30. Name and

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of dertifier

29c. License number 065292

29d. Date signed (Month, Day, Year)

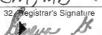
dress of person who completed cause of death (Item 23a) (Type, Print)

9/13/08 n. Ohey MO20832

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 15



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** 2:50 PM 12 SEPT. BETTY MAYO COMEGYS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | Min. | MAY 17, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** ^{Year)} 1939 Months 1 □ M 2 💢 F MISSISSIPPI Director 577-56-8366 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1X Yes 2 No Director CENTREVILLE **OUEEN ANNE** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ural", or items 23a or Examiner must be USA 21617 205 HOLLY STREET Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within \$2 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CHIEF DEPUTY CLERK MARYLAND JUDICIARY 2 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be innent of Health and Mental VIRGINIA MONTGOMERY C.B. MAYO ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 205 HOLLY STREET, CENTREVILLE, MD 21617 JOHN E. COMEGYS/ HUSBAND Health a tem 27 is 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 9-16-2008 CENTREVILLE, MD CHESTERFIELD CEMETERY Important: If any Injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Juneral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aplashu anemia mark **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of the sequence of the Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one MENTERT Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 21 No Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death.

To the Funeral Director: /

10

2008 State

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

29c. License number DSZ830

29d. Date signed (Month, Day, Year) September 12, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

wern, MP 900 Brstgate Re #300, Amapolis mp Z1401

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 **Physician** 2008 2:05 P M 11 Cecilia Crawford /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Laurel Regional Hospital Prince George Laurel Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y) 1/7/1915 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 ☐ M 2 🔀 F 93 Arkańsas 425-14-3235 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 K No Director MD Worcester Ocean Pines 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 131 Pinehurst Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Moore Copeland Margaret Mary Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark R. Crawford / son 5505 Margate St., Springfield, VA 22151 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State MD Veterans Cemetery 9/15/2008 4 ☐ Donation 5 ☐ Other (Specify) Dorchester, MD 21. Signature of Funer 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter the desage, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute renal failure Due to (or as a consequence of): respiratory failure Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner breast cancer Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Deconditioning 1 Tyes 2 No 3 Probably 4 XUnknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No 1☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner requires that the death certificate be executed burial-transi Division or Vital Records, P.O. Box 68760, physician the for use as ned by the a s been signe should be d page 2 s certificate Physician: After this certification funeral director, this

Funeral

Director

"natural", or Items 23a or 28a-f show dral Examiner must be notified at

the Medical

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i

Physician /Medical

Baltimore, Maryland 21215-0036

or Attending death. ours after death.

neral Director: A
filled in by the fu To the Hospital o within 24 hours aft To the Funeral Di completely

BA 10

Mythily Vancha State

29a. Certifier

29c. License number

D0064760

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 9/11/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7300 Van Dugen Rd., Laurel, MD 20207

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SEP 1 6 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death Day 9, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SEPTEMBER FRANCES ELOISE 2008 COWAN 11:52A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVERSPRING Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 1 F Months Days Hours 02-08-1929 NORTH CAROLINA **Director** 240-36-6790 79 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State show of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be rediffied at MD PRINCE GEORGE LANDOVER Director 1 NYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 7907 EAST NALLEY DRIVE LANDOVER U.S.A. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐Yes 2 X No Specify. ⋛ 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5-1-SCHOOL TEACHER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM BILLY ANDERSON ဂ LEONA ANDERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT N. COWAN SR./SON 866 DEVEREAUX DR VIRGINIA BEACH, VA 23462 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of Important: If it
any Injury or o ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY09-12-2008 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOPULMONARY ARREST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** HYPOXEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans PNEUMONIA Due to (or as a consequence of): P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical ACUTE MYOCARDIAL INFARCTION IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ HYPOTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No ACUTE RENAL FAILURE 24a. Was an certificate 2 🖾 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: A 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

Registrar

State

10

Then

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

SMITHA BHIKKAJI, MD 1500 FOREST GLEN ROAD SILVER SPRING, MD 20910

29c. License number

D0064100

29d. Date signed (Month, Day, Year)

09-09-2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 10:35 a M 11, W. Gifford Crothers September 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** North East 8. Date of Birth (Month, Day, Year) 207 Riverside Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 X M 2 □ F Pennsylvania 1931 164-26-9606 77 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10h. County 10a. State Show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Cecil North East Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 1 21901 U.S.A. 207 Riverside Drive death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examiner TM□Yes 2□No
If Yes, Give
Year or Dates: 1953-55 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Crothers' Market Elementary/Secondary (0-12) College (1-4or 5+) Six Years Port Deposit, Maryland Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Schulthise W. Gifford Crothers P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 207 Riverside Drive, North East, Maryland Barbara S. Crothers (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State North East, Maryland 09/16/08 North East Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIPLE YEARS **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Completed by Physician/Medical SS attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 2 No RENAL FAILURE 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy performe 2 🔀 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred after death. 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier Cause of death (Item 23a) (Type, Print)
D 10755 FALLS RD, SUITE 200 LUTHERVILLE) 30. Name and addre J. SEIFTER, MI 3

State Registrar

31. Date filed (Month, Day, Year)

SEP 1 6 2008

VI

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 10, 2008 Physician 15:00 ROBERT LEE DAISEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 01 ney Montgomery Montgomery General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 17, 1935 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Virginia 1 M M 2□ F 73 220 32 1161 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a." ehror any lighty or other traumatic event, the Medical Error pince. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Montgomery 01nev Md. Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number United States 20832 17935 Dumfries Circle Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1957 -If Yes, Give Year or Dates: 1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U. S. Government Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Pearl Tatem Daisey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17935 Dumfries Circle, Olney, Md. 20832 Eleanor M. Donaghue - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 9/16/08 Silver Spring, Md. 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Line nsee 22MName and Address of Facilities Funeral Home m-00970 P.O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final disease or condition resulting in death) Months Adenocarcinoma of hepatobiliary duct **Physician** /Medical Due to (or as a consequence of): **Examiner** Pneumonitis Sequentially list conditions. Due to (or as a consequence of) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1∐ Yes 1 ☐ Yes 2NNo certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To this 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide completely filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 15, 2008 D 42452 30. Name and address of pers who deleted cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D. 18111 Prince Philip Drive, #327, Olney, Md. 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Bear & Registrar 5 2008

		1 - State Registrar		(Certificat	e of Dea	th	1	Reg. No. 🚄	.008 3	107
		1. Decedent's Name (First, Midd	le, Last)					. Date of Dea			e of Death
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Exam		4a. Facility Name (If not institution			_	Town, or Local	tion of Death			inty of Death	
		19617-L Gunner				ntown				gomery	
Funera		5. Social Security Number	6, Sex 7. Age 1	(In yrs. last birth	nday) If Under Months	Days Ho	nder 24 Hrs. 8	Date of Birl (Month, Da OV 27,	th ly, Year)	9. Birthplace (Sta Country) Ok Lahoma	ate or Foreign
Directo	r	487-38-6981 Usual Residence of Decedent		73 Y	15.		IA	ov 2/,	1934	UKTanoma	
and		10a. State 10b. County	,	10c. City, Town	or Location					10d. Insid	e City Limits
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at yiellid AIAI3-0030 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Publical Evention in the Demotified at	Completed	15. Deceder	nt's Education est grade completed)	1 (Decedent's Usua Give kind of wo	rk done durina	most of working		16b. Kind o	f Business/Industry	
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be find here	Be	17. Father's Name (First, Middle, Herbert Koen M	•				se Ursu			name)	
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Vial 12 st than 7 is n traun		19a. Informant's Name/Relation: Lisa D. Dean/d								wn, State, Zip Code) 1, MD 20874	+
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Profice Exemine must be notified at any injury or other traumatic event, the Profice Exemine must be notified at any injury or other traumatic event, the American Exeminer must be notified at any injury or other traumatic event.		4 ☐ Donation 5 ☐ Other (3		Criesape	T		<u> </u>			4 1	
permi Depa Impo any is		Bana a. L	H.)-H	MO10E1						0. Box 784	
-		23a. Part 1. Enter the sease, o	r complications that caused	the death. Do no	ot enter the mod	フ し、 当色 le of dying, suc	ckroffe th as cardiac or	, P.A. respiratory a	CLark rrest,	sville, M	imate
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sicia certi	Be	25. Was case referred to medical examiner? 1 Yes 2 You	Hospital:	O		Othor:	Place of Death (1011-10	
P P C	1:1	27. Manner of Death	28a. Date of Injur	nt 2 ER/Out		JA 41	Nursing Home		dence 6 L		
Affe fune	Certification:	1 Natural 5 ☐ Pendi		<i>(,Year)</i> In	jury M	28c. Injury at Work? 1 □ Yes			, ,		
Atter r dea ector	Hica	3 ☐ Suicide 6 ☐ Could		ry - At home, farr	n, street, factor	, office	28			umber or Rural Route	Number,
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ospital or hours afte uneral Dire			Examiner: On the basis of		or investigation	i, in my opinion	, death occurred	at the time,	date and pla	ce, and due to the cat	
he Hospital or in 24 hours afte he Funeral Dir	edical		and manner sta		1				00-L D-L!		
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for un	Medical ((Check only 2 Medica				c. License num	ber			gned (Month, Day, Ye	
To the Hospital or within 24 hours afte To the Funeral Director completely filled in I	edical	(Check only 2☐ Medica one)		1D		51465	ber			nber 15, 20	
To the Hospital or within 24 hours afte To the Funeral Dire completely filled in 1	edical	(Check only 2 Medica one) 2 Medica 29b. Signature and title of certification of the one of the o	n who completed cause of de		De Type, Print)	51465			Septem	ber 15, 20	800
(Pa)	Medical	(Check only 2 Medica 29b. Signature and title of certific 30. Name and address of persor Megan Wollman-I	who completed cause of de	D. 20528	De Type, Print)	51465			Septem	ber 15, 20	800
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#24a/b, 25pcmMD 9-16-08, BWW, Mcoc Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) Day Month Year Physician Eddie - Fisher 2008 SAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland Year If Under wiversity of 8. Date of Birth (Month, Day, Year)
Dec. 23.1964 9. Birthplace (State or Foreign 6. Sex Social Security Number (In yrs. last birthday, **Funeral** Months Days Hours Min. Puerto Rico 1 ☐ M 2 🖾 F 43 230-86-2959 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County show iral", or items 23a or 28a-f shov Examinar must be notified #1 MYes 2□No Director Anne Arundel Pasadena MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21122 7860 Levy Ct. Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🙀 No Specify Specify: Black Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Eddie, Jr. Minnie Lee Arnold P other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21144 Severn, Maryland P.O. Box 813 Latoya Eddie/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any injury or o t⊈ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/8/08 Petersburg, VA Dinwiddie Memorial 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 0 3831 Georgia Ave. N.W. Wash., D.C. 20011 278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septicemia disease or condition resulting in death) /Medical Due to (r as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician for use as the buria Box 68760 Physician/Medical as IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 2 100 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 📈 o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 XYes 2 □ No certificate 2 **X**No 1 ☐ Yes Division of Vital 9 Hospital or Attending Physician: 24 hours after death.
9 Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2X No After this of funeral din ၉ 27. Manner of Death 1 Anatural 2 Accident 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. To the within 2. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar PINTE

31. Date filed (Month, Day,

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32. Registrar's Signature

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Year,

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State of Maryland / Department of Health and Mental Hygiene 2008 31078 Amenthius Latoyne Frazier Certificate of Death 1. For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day September 4, 2008 Physician/ 1445 hrs Amenthius Latoyne Opal Frazier ~\ Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's **Bowie Health Center** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 1983) Foreign Washington. If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Country) D.C. Months Days 25 February 17, M 2 X F Director 579-06-8616 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Bowie 28a-f show Prince Georges Maryland with the Maryland 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number **United States** 20720 23a or 2 6002 Grenfell Loop 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. š Armed Forces 1 X Never Married 2 Married hours after death Yes 2 X No Specify: Black 9 Yes 2 X No specify: Divorced If Yes, Give Year 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 2 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) pe United States College (1-4 or 5+) Elementary/Secondary (0-12) d Mental Hygiene. s marked other than "r ic event, the Me it al E Pages 1 and 2 should be filed within 72 Innent of Health and Mental Hygiene. Complet Homeland Security Investigative Specialist 21215-0036 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frazier Marilyn Eleathia Curtis Bogan Maurice Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002019a. Informant's Name/Relationship (Type, Print) 3042 Stanton Road, S.E.; Apt. 103; Washington, D.C. item 27 is Marilyn E. Frazier (Mother) 8 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, Sept. 13, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Washington, D. C. 2008 permit. Page:
Department o
Important: **Glenwood Cemetery** Donation 5 Other Specify 22. Name and Address of Facility Company Morticians, Inc. 21 Signature o Funeral Service Licenses 600 Kennedy Street, N.W.; Washington, D.C. andles Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death **fledical** a. Multiple Injuries Immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and cal AMENDED UNPENDED ysician burial -Physician/Medi 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE phy the b Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 🗸 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0 Yes 2 No 3 Probably 4 V Unknown þ 24a. Was an 24b. Were autopsy findings available Completed Records, prior to completion of cause of autopsy performed? death? has 1 🗸 Yes No 1 🗸 Yes 2 certificate 26. Place of Death (Check only one) 25. Was case referred to medical Physician: of Vital Other₄ Be Nursing Home 5 Residence 6 DOA 2 V ER/Outpatient 3 Inpatient this No 1 Yes 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury ospital or Attending Ph. vin 24 hours after death. e Funeral Directors 27. Manner of Death Subject driver of vehicle in motor vehicle Certification: Sep 4, 2008 1417 hrs Yes 2 ✔ No Natural laccident 28f. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 15400 block Annapolis Road, Bowie , MD Could not be Suicide (Specify) Major Road / Highway determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME September 5, 2008 O.C.M.E. and 30. Name and address of person who complete cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Registrar's Signatur 31. Date filed (MSEP 1Yeq) 2008 State Registra

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - State Of IV State Registrar	-	artment of Health rtificate of Deat		Reg. No. 200	8 31079	
ician	1. Decedent's Name (First, Middle, Last) Dalia K. Gilpi	L n		2. Date of Do Month Septer	mber 12, 20	3. Time of Death 9:15 A M	
miner	4a. Facility Name (If not institution, give street and number 5225 Pooks Hill Road, # 16	519S	4b. City, Town, or Location Bethesda		4c. County of De	mery	
ral tor	5. Social Security Number 112-38-0322 Usual Residence of Decedent 6. Sex 1 □ M 2 □ F 7. A	ge (In yrs. last birthday) 63 Yrs.	Months Days Hour	der 24 Hrs. 8. Date of Bi Min. (Month, D July	Day Year) (rthplace (State or Foreign Country) srae1	
tor	10a. State 10b. County Maryland Montgomery	10c. City, Town or Lo				10d. Inside City Limits 1	
al Director	10e. Street and Number 5225 Pooks Hill Road, # 16		10f. Zip Code 20814		10g. Citizen of What C		
once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 1 □ Vas Deceden Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates	No .	Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 □Yes 2 X No Spec			nerican Indian, ite, etc. White	
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life. I	dent's Usual Occupation kind of work done during n DO NOT use retired) veler	nost of working	16b. Kind of Business/Industry Jewelry		
To Be C	17. Father's Name (First, Middle, Last) Zwi H. Kosczuk			other's Name (First, Middle Ursel Rosen			
	19a. Informant's Name/Relationship (Type. Print) Denny L. Gilpin - Husband	d 5225	ng Address (Street and Nu. Pooks Hill I	Road, # 1619	S, Bethesda	, Md. 20814	
	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Judean Me	sition (Name of matory or other place) em. Gardens Name and Address of Fa	9/14/2008	Olney, Ma	ryland	
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a	is a consequence of): is a consequence of): is a consequence of):					
Physician/M		2 ☐ Fetal death 3 ☐ at time of death 5 ☐	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of o	Day Year	
by	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Pa		tobacco use contribute	to the cause of death? Probably 4 Unknown	
Completed	Of Was seen referred to medical			per 1 □Yes	opsy prior t formed? death 2 X No 1 □ Ye	autopsy findings available o completion of cause of ?	
o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa	tient 2 ER/Outpatier	Othor	ace of Death (Check only] Nursing Home 5K Res		necify)	
ation: To	27. Manner of Death 1 XNatural 5 Pending (Month, L	jury 28b. Time o		28d. Describe	e how injury occurred	Journal	
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Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best and manner and manner services.	of examination and/or in	vestigation, in my opinion,	death occurred at the time	e, date and place, and d	ue to the cause(s)	
Z	29b. Signature and title of certifier	an -		55258	29d. Date signed (Mo		
State	30. Name and addres∯of person who completed cause of Gary B. Wilks, M. D. 609. 31. Date filed (Month, Day, Year) 3₽ Regis	5 Marshalee	Drive, Elkr	idge, Maryla	and 21075		
State jistrar	SEP 15 2008	w It for	de la la la la la la la la la la la la la				

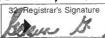
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			State of Maryland / Department of	Health and Mental Hy	giene 2008 31080
			1 - State Certificate o		Reg. No.
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year
	/Medic	al	WILLIAM EDWARD GIBSON	SEPT.	11, 2008 3:40 A ^M 4c. County of Death
	Examin	er		or Location of Death Thersburg	MONTGOMERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Yes	r If Under 24 Hrs. 8. Date of Birt	
	Funeral Director		217-42-8726	s Hours Min. (Month, Da Apr. 1	5,1945 Maryland
	land ow		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary Firsh	tor	MD Montgomery Gaithersk	urg	1 □ Yes 2 📉 No
	with the	I Director	10e. Street and Number 21307 Woodfield Road 20	9882	10g. Citizen of What Country? U . S . A .
36	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, if m. M. digil Enamine must be notified at	by Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 1 □ Ves 2 □ No If Yes, Give Year or Dates; 1 □ Ves 2 ☑ No If Yes Give Year or Dates;	f Hispanic Origin? (Specify Yes or No uban, Mexican, Puerto Rican, etc.) lo <i>Specify</i> :	- 14. Race - American Indian, Black, White, etc. Specify: Black
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	filed withi Hygiene. ther thar	Son	11th Lab Te	1	N.I.H.
Maryland	be od o	To Be	17. Father's Name (First, Middle, Last) William D. Wood	18. Mother's Name (First, Middle, Eleanor Gi	•
	12 m	ľ		et and Number or Rural Route Numb dfield Rd, Gait	er, City or Town, State, Zip Code) :hersburg ,MD 20882
Je,	of Hez item		20a. Method of Disposition 20b. Place of Disposition (Name of cemeter), crematory or other processing and compared to the processing of t	Date	20c. Location - City or Town, State
<u><u>Ĕ</u></u>	nit. Page partment o ortant: If Injury or		And December 1 Connected Emory Grove Ce	em : 9/16/08	Gaithersburg, MD
Baltimore,	permit. Pages of Department of Important: If ite any Injury or of Office.		21. Sign flury of Funeral Service Liu ns-e 22. Name and Ad 246 N.	tress of Facility SNOWDEN Washington St,	FUNERAL HOME, P.A. Rockville, MD 20850
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause on each line.	dying, such as cardiac or respiratory a	interval between
1	Physician		Immediate Cause (Final disease or condition _a. Cancer of the Gall	Bladder	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	- Landing	
	Examiner	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):		
K	nsit	Examiner	Sequentially list conditions if any, leading to Immediate auss. Enter Underthing Cause (Disease or injury that initiated events		
Η,	icate be executed physician and s the burial-transit	zar	that initiated events resulting in death) Last C Due to (or as a consequence of):		
8760,	e be	dical	d		
9	tificat ig phy as th				
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
٩.	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 23e. Did	tobacco use contribute to the cause of death?
rds	equires en sign tuld be	d by		1 🗆	Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown
Records,	law re has be	Completed		24a. Was auto perfc 1	
Vital		Bec	25. Was case referred to medical examiner?	26. Place of Death (Check only	
of V	d is	70 E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 In Nursing Home 5 XRes	idence 6 Other (Specify)
ion o	ng Affer Ine			njury at 28d. Describe Vork? ☐ Yes 2 ☐ No	how injury occurred
Division	al or Attending s after death. I Director: After ed in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	e 28f. Location (City or To	Street and Number or Rural Route Number, wn, State)
	To the Hospital or within 24 hours aft To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the death of my knowledge, death occurred at the death of my knowledge, death occurred at the death of my knowledge, death occurred at the death of my knowledge, death occurred at the death of my knowledge, death occurred at the death of my knowledge, death occurred at the death occurred at	e time, date and place, and due to the sy opinion, death occurred at the time	e cause(s) and manner as stated, date and place, and due to the cause(s)
	vithin To the	Me		ense number D64615	29d. Date signed (Month, Day, Year) 9/11/08

State Registrar

Genevieve Wroblewski, M.D. 31. Date filed (Month, Day, Year) SEP 15 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1355 Piccard Drive, Rockville, MD 20850

08-07223 Carroll Golebieski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physici	an/	Decedent's Name (First, Middle,Last)	, , ,	`		2. Date of De		3. Time of Oeath
edical Exam	iner	CHVVOLL LVANCIS GOLEDIESE	KI, JR.	1, 2, 2	,		Day Year er 22, 2008	0900 hrs
er:		4a. Facility Name (if not institution, give street and number) Comfort Inn		4b. City, Town Easton	, or Location o	Death	4c. County of Death Talbot	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday	/) If Under 1	Year If Under	r 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Birt	
Director		219-15-5822 1XM 2 F	26	Yrs. Months [Days Hours	Min.	30,1982 Foreig	RYLAND
y		Usual Residence of Decedent	10c. City, Town or L			1	30,1302 12	
i Iow any e.			•					10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once	Director	MARYLAND CAROLINE 10e. Street and Number	PRESTO	10f. Zip Cod	e		10g. Citizen of What Cour	
vith the Maryland s 23a or 28a-f show notified at once	Dire	6300 STATUM ROAD		2165	55		UNITED STA	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health Montal Hygien was the marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent E	Ever in U.S. 13.			in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Race - Ameri White, etc.	can Indian, Black,
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imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Inten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Be C	17. Father's Name (First, Middle, Last)	-		111	s Name (First, Middle,	ŕ	
212 ould be Ments mark c even	To B	CARROLL FRANCIS GOLEBIESKI 19a. Informant's Name/Relationship (Type, Print)		ailing Address (S		HANTE FRAN ber or Rural Route Nu	ICKOWIAK Imber, City or Town, State	Zip Code)
MD d 2 shc lth and n 27 is		STEFANIE D. GOLEBIESKI/WIFE	- 1				MARYLAND 21	
Baltimore, ML permit Pages I and 2 s Department of Health an Important: If item 27 injury or other traums		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dis	sposition (Name of	cemetery.	SEPT. 27	20c. Location - City or	
Page Page ment c		4 Donation 5 Other Specify:	1	EMETERY		2008	STEVENSVIL	LE, MD
Balt Permit Depart Impor injury		21. Sen autre of Funeral Service Licensee	2	FELLOWS,	ress of Eacility HELFE	NBEIN & NE	WNAM FUNERAL	HOME, P.A.
Physician		23a. Part I. Enter the disease, or complications that caused the	he death. Do not en	106 SHAN ter the mode of dyi	ng, such as ca	OAD, CHEST ardiac or respiratory a	TER, MARYLANI rrest, shock, or heart	21619 Approximate Interval
'Medical	0.1	failure. List only one cause on each fine! Immediate Cause (Final disease a. FAtty live	r					Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consection)			1	III Fyri		
	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consec	quence of):		-	_		
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760, ficate be ex g physician the burial		IF FEMALE: 23b. Was decedent pregnant in the	e of pregnancy				23d. Date of delivery	
Box 687 death certifices the attending part of for use as the	Physician/	past 12 months?	ime of death 5	Fetal death Other (Specify)	3 Ectopic	pregnancy	Month E	ay Year
Bo ne deat the at	hys	1 Yes 2 No 9 Unknown 9 Unknown						
ires that the signed by	by	Part II. Other significant conditions contributing to death Chronic alcohol abu		the underlying caus	se given in Par		tobacco use contribute to es 2 No 3 Prob	
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of Vital ng Physician: fiter this certi	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	t 2 ER/Outpat		Other ₄	Nursing Home 5	Residence 6 🗸 Other	: Scene
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Division ital or Attendir as after death. "al Director: Alled in by the fu	Certification:	determined (Specific)	ry - At home, farm,	street, factory, offic	ce building, etc	28f. Location or Town,	(Street and Number or Ru State)	ral Route Number, City
Hospi 24 hou Funcr		4 Homicide 29a. Certifier Certifying Physician: To the best of my	knowledge, death o	ccurred at the time	, date and plac	ce, and due to the car	use(s) and manner as state	ed.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of exami and manner stated.						
- 2 - 3	ĕ	29b. Signature and title of certifier			ense number		29d. Date signed (Mor	
		Yande / Duthell M)		О.	C.M.E.		September 23, 2	008
		30. Name and address of person who completed cause of dea Pamela E. Southall, MD Assistant Medic		111 Penn Str	eet. Baltim	ore, MD 21201		
St	tate		s Signature	1	os, Danim	0.0, 1415 2 (201		
Ragie								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 9, 2008 **Physician** Millard Earl Grant 11:55 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days 1 🖳 M 2 🗆 F 223-44-2832 1937 North Carolina Director 71 August Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Exeminar is ust by notified at 1 X Yes 2 □ No Director MD Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 7467 Village Green Terrace 20785 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No Arπ
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify: <u>م</u> Specify. 3 ☐ Widowed 4 K Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Correctional Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked oth Columbus Grant Dolly Futrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mary F. Williams/sister 7467 Village Green Terrace, Landover, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 9/16/2008 Landover, MD Signature Funeral Fervice Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** & carried /Medical Due to (or as a consequence of): Examiner atherosc lenote Conner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗔 No 1 ☐ Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) Injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

9-4 B

> State Registrar

29b. Signature and tit

1328 Southern avenue SE Suit 310 Washington DC Palmen 31. Date filed (Month, Day, Year) SEP 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mi

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#180er FH. 9-18-08. BMW. MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SEPTEMBER 2, 2008 Physician \mathbf{P}^{M} NORMAN **RAY** HEMBY 6:03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oxon Hill If Linder 1 Year | If Under 24 Hrs. Prince Georges
9. Birthplace (State or Foreign 1313 Iverson Street 8. Date of Birth (Month, Day, Year)
July 29,1945 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 63 D.C. 577-62-4810 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 √Yes 2 No Director MD Prince Georges Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number d 2 should be filed within 72 hours after death with th and Mental Hygiene. It is marked other than "natural", or items 23a or traumatic event, the M dical Examiner must be r 1313 Iverson Street 20750 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 Xyes 2 No IETNAMIf Yes, Give
Year or Dates: —FRA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1: Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) U.S. Postal Supervisor Federal Government permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, the 18. Mother's Name (First, Middle, Majden Surname)
Mildred Barrett
Mana Pagarott 17. Father's Name (First, Middle, Last) Be Joseph Hemby ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Marie Hemby/Daughter 702 B-Barrington Dr. Waldorf, Maryland 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Cheltenham Veterans Sept.12,2008 Cheltenham,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7 278MD 3831 Georgia Ave. N.W. Wash.,D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC RENAL FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner HYPERTENSION** Sequentially list conditions, if any, loading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2X No 24a. Was an autopsy performed? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD# 0101233709 SEPTEMBER 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL E. HERMAN, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

31081

			for Stata Registrar	State of Ma	arytanu		rtificate				Reg. No		31004	1
	* Division	Ç	1. Decedent's Name (First, Middle	, Last)						2. Date of Dea	ath Da	ay Year	3. Time of Death	
X	Physici /Medio		CLARA HOCH									13, 2008	3 6:50 A M	
	Examin	er	4a. Facility Name (If not institution,	give street and number)					ocation of Death		4c. County of Death			
			WILSON HEALTH				If Under 1		HERSBURG If Under 24 Hrs.		MONTGOMERY			_
- 17 14-6	Funeral Director		087-30-5743	6. Sex 7. Age 1	92	Yrs.		Days	Hours Min.	8. Date of Birt (Month, Da 07/11/	у, _{Уваг} 1916	HUNC	nplace (State or Foreign untry) GARY)
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	ath with the Marylan 23a or 28e-f show	to	MARYLAND MONTGO	OMFRV	CATTI	HERSB	IIRG						X□Yes 2□No	U
	r 28a	Director	10e. Street and Number	OTILICI	OAIII	шиор	10f. Zip (Code			10g. C	itizen of What Cou	untry?	_
	h with	ai D	4 TURNHAM LANE				208	378			USA	4		
	after deal	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13.			panic Origin? (Spe , Mexican, Puerto	ecify Yes or No-		14. Race - Amer Black, White		
215-0036		by	1 ☐ Never Married 2 ☐ Marrie 3 ※ Widowed 4 ☐ Divorced		lo		1 □ Yes 27			, , , , , ,			HITE	
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yıand	d be ental ked o	To Be	MARTON APFELBAU						VILMA DU			,		
	should ind Man marke umatic	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street ar	nd Number or Rura	al Route Numbe	er, City	or Town, State, Z.	ïp Code)	_
Mar	27 to		PETER HOCH-SON		4	4 TUR	NHAM I	LANE	, GAITHER	RSBURG,	MAI	RYLAND 2	20878	
ore.	ges 1 au it of Hea if Item or othe		20a. Method of Disposition 1X□ Burial 2 □ Cremation	312 Demoval from State			sition (Name)	Date	20c. l	ocation - City or 1	Town, State	
saitimore,	permit. Pages Department of I Important: If It ony injury or o		4 □ Donation 5 □ Other (Sp	pecify)	WELL		CEMETI			5/2008	FAI	RMINGDALE	E, NY	_
g n	Depa Impo eny ii		21. Signature of Funeral Service L	L CONCOR		E	Name and DWARD 091 RC	SAG	EL FUNERA	AL DIREC	CTI(VILI	ON, INC. LE, MARYI	LAND 20852	
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	only one cause on each lin	ю.					3			Approximate Interval Between	
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	2 0 4	Med	IF FEMALE:											
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r	The lav ate has page 2 a	mo	divertice	Maris						autop perfo	rmed? 2 2 N	death?	completion of cause of	
VII	ian: artifica ctor, p	ВеС	25. Was case referred to medical examiner?						26. Place of Death			0 12.00		
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sion	ing Ifter	ation;	27. Manner of Death 1		Year) 28	Bb. Time of Injury	f 28	c. Injury a Work? 1 \(\) Ye		28d. Describe l	now inji	ury occurred		
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		1	For State Registrar	State of	Maryland		irtmeni <i>tificate</i>			Mental H	ygiene Reg. No.!	711118	31085
			Decedent's Name (First, Middle, Lass)	t)				-		2. Date of D		Vasa	3. Time of Death
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uk.	/Medic		Helen Kraus 4a. Facility Name (If not institution, give		ber)		4b. City.	Town, or	Location of Dea			County of Deat	
	Examin	er			501)							Howard	
			9331 Many Flowers 5. Social Security Number 6. S	s Lane	. Age (In yrs. la	st hirthday)	Jess If Under		If Under 24 Hrs	8. Date of B	irth	9. Birt	hplace (State or Foreign
	Funeral		1	_M 2⊠ F		37 Yrs.	Months	Days	Hours Min	09/10	/ 1 0 2 0		Diego, CA
	Director	-	215-38-2574 Usual Residence of Decedent			07				09/10	1920	Jan	Diego, CA
	and		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	f sho	ō	MD Howar	e d		7.							1. Yes 2 □ No
	he \n	Director	MD Howai	<u> </u>		Jes	10f. Zip	Code			10g, Citi	izen of What Co	untry?
	with be per						10.1.0		0=0/			****	
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36	or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 □Yes 2 If Yes, Give	•	1	1 □Yes 2	2⊠No	Specify:			Specify:	
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Baltimore,	permit. Pages Department of Important; If i any Injury or once.		21. Signature of Funeral Service Licer	isee 7									Home, Inc.
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7	Examiner												
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Box	attel for L	ciar	in the past 12 months?		irth 2 ☐ Fetal ant at time of d		☐ Ectopic p ☐ Other <i>(st</i>		у		_	Month	Day Year
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σ.	that the		Part II. Other significant conditions of	contributing to de	ath but not resu	itting in the u	nderlying o	ause giv	en in Part I.	23e. D	d tobacco	use contribute t	o the cause of death?
ds,	signed be det	ð.	Hypertrophic Hear	t Diseas	Se					11	Yes 2	1 No 3 ☐ F	Probably 4 Unknown
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Λ	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical	one)	and mann	ner stated.							ate signed (Mor	
7	To vit	2	29b. Signature and title of certifier	1			29	o. Licens	se number	- 6	290. 0	are signed (IVIOI	C.
			to pela		ren	o ho	>	<u>ー</u>	+ 22.	15	104	1041	7009
	10		30. Name and address of person who	completed caus	e of death (Item	1 23a) (Type,	Print)	102					
_	, -		Angela Duncan, MD		Vandus		1d # .	103	Laurel,	MD 20	707		
		ate	31. Date filed (Month, Day, Year) SFP 1 1 2008	32. R	egistrar's Signa	tur	1						
	Regist	rar	CED 1 1 7000	THE REAL PROPERTY.	, , , ,	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 11, 2008 11:50 P^M Thomas Francis Howard 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Montgomery General Hospital 01nev 8. Date of Birth (Month, Day, May 8, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Washington, D.C Months Days Hours 1 XM 2 □ F 577-28-2875 86 Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Montgomery 01nev 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 Lindenwood Court 20832 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰/es 2 □ No If Yes, Give Year or Dates: 1942–45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant/Auditor Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Dowling Frank R. Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Lindenwood Court Olney, MD 20832 Kathryn S. Howard/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ②☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 09/13/08 Beltsville, MD 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumoni a disease or condition resulting in death) ue to (or as a consequence of) Due to for as a consequence of Due to (or as a consequence of) yes, outcome of pregnancy 23d Date of delivery Month Day Year

Physician /Medical Examiner

Injury or

Department Important: If any Injury o

Physician

/Medical

10a. State

MD

Director

Funeral

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Completed

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

. Pages 1 and 2 should be file treent of Health and Mental H tant; If Item 27 is marked oth

Saltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at

use as the burial-transi and physician

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Be Certification: To

To the Funeral Director: After this certificate has been signed by the attending I To the Funeral Director. After this certificate has been signed by the attending I To the Funeral director, page 2 should be detached for use as

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed Medical 2 1241 State Registrar

Sequentially list conditions, if any least 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 \(\text{Homicide} \)

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 Unknown

3 🗆 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 ☐ Yes

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

3 Probably

1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury 5 Pending investigation (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check onl one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

2008

29c. License number

29d. Date signed (Month, Day, Year) -57

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

Montgomer 32. Registrar's Signature

			For State	State	of Mar	yland / Depa				and M	lental Hy	gien	е		0.1.0.0
			Registrar 1. Decedent's Name (First, i	Middle Last)		Cer	tificate	OTL	<i>Jeatn</i>		2. Date of De	Reg. N	0. 7	<u> 1118</u>	3 08
	Physic	ian	HARold	2		Ja	has	ON			AUgus +	D	ay	Year	11: 25 PM
N C	/Medi Examii		4a. Facility Name (If not inst	itution, give street and	number)	00			Location of		1109031		c. County	of Death	117
	LXuiiii	ici	The Johns Hopl	kins Hospita			Baltir	more	City						
1	Funeral Director		5. Social Security Number 557–28–9369	6. Sex 1 🔀 M 2 □		(In yrs. last birthday) 35 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug 25	th ay, Year) 19	23	9. Birthp Count Iowa	
	and ow		Usual Residence of Decede 10a. State 10b. Co		1	10c. City, Town or Lo	cation							1	I0d. Inside City Limits
	Maryl I-f sho led at	ţ	MD Mo	ntgomery		Potomac									1. Yes 2 □ No
	h the	Director	10e. Street and Number	-			10f. Zip-	-Code				10g. C	itizen of W	/hat Coun	
	th wit		11105 Bella	vista Driv	e		20)854				Un	ited	Stat	tes
	tems er mu	Funeral	11. Marital Status	12. Was I	Decedent Eve d Forces?	er in U.S. 13.			spanic Ori n, Mexican	igin? (Spe	cify Yes or No Rican, etc.))-		e - Americ k, White, e	an Indian, etc.
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show nt, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2½ 3 ☐ Widowed 4 ☐ Dive	If Yes	es 2 □ No , Give or Dates:		1· ☐ Yes 2		Specify:				Specify	<i>r</i> .	
21215-0036	2 hou atural		15. Dec	cedent's Education		16a. Dece	dent's Usua	al Occupa	ation			16b.	Kind of Bu	Whi	
215	thin 7: e. an "na Medic	Completed	(Specify only a Elementary/Secondary (0	highest grade complet 0-12) Colleg	ed) e_(1_4 or 5+)	life.	kind of wor DO NOT us	e retired)	_	t of worki	ing			-	
	ed wil	5) +	Brig	adier	Gen					S Air		ce
Maryland	12 should be filed within ' h and Mental Hygiene. 7 Is marked other than "I traumatic event, the Med	Be	17. Father's Name (First, Mid	,				Ì			e (First, Middle	e, Maide	en Surnam	10)	
ž	hould d Mer marke natic	욘	Harold John 19a. Informant's Name/Rela			19h Maili	ng Address	(Street s			Cooper	or City	or Town	State 7in	Codo)
Ma	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Maria Baci		Wife						e, Pot				
ē,	s 1 and 3 if Health item 27 other tra		20a. Method of Disposition		_	20b. Place of Dispo cemetery, crei	sition (Nan	ne of	Cem		ate	20c. l	Location -	City or To	wn, State
Baltimore,	permit. Pages Department of I Important: If ite any Injury or of		f ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ott		om State	Arlingto				Nov	10,200	B A	rling	gton,	VA
alti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Ser	vice Licensee					s of Facilit	y Jos	eph Gav	wler	's S	ons,I	INC
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d	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		monia									2 weeks
٧	Examiner		, country	Due	to (or as a c	consequence of):			1 .	.)					2 11.
		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b	to (or as a c	E Lig Cl	ogen	009	200	ukc,	n i fi		-	-	2 mon 1/13
	uted	Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events	c.	Muc	1024501	ostic	: :	sund	ron	16			1	14 months
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Вох	eath certif attending d for use a	iciar	23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No	" 1 L		Fetal death 3	Ectopic p		'			Ì	23d. Date Mor	e of delive nth	Day Year
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	s that ned b se det	by P	Part II. Other significant co	nditions contributing	to death but	not resulting in the u	ınderlying (cause giv	en in Part	l.	23e. Did	tobacco	use conti	ribute to th	he cause of death?
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al F			05.14								1 🗆 Yes	2 2		death?	2 No
Zit	Attending Physician: The death. sctor: After this certificate by the funeral director, par	Be c	25. Was case referred to me examiner? 1 ☐ Yes 2 🛣 No	111	Inpatient	0 7 58/0 45 45		Othe	F.		(Check only o			40 15	
1 0	ding Phys h. After this funeral d	일	27. Manner of Death	28a. D	ate of Injury	28b. Time o		8c. Injury	at		ne 5 Resi 28d. Describe			er (Specify red)
sior	ttending death. tor: After y the fune	atio	2 Accident	vestigation	fonth, Day Ye	ear) Injury	М	Work 1 □ Y	? ⁄es 2 🔲 l	No					
Division	l or Atten after deat Director:	Certification:			ace of injury uilding, etc. (- At home, farm, str Specify)	et, factory,	office		1	28f. Location City or Tox	(Street a	and Numb e)	er or Rura	al Route Number,
	Hospital or 24 hours afte Funeral Dire stely filled in		29a. Certifier 1 🗷 Cer	difulne Dhualalan, To	the best of se	nu knowledno dosti		-4 4t 41		d alasa			· · · · · · · · · · · · · · · · · · ·		
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		For	State of Ma	aryland /	Depa	rtment of H	ealth and N	1ental Hy	giene		
	-	- State Registrar			Cer	tificate of L	Death		Reg. No.	2000	21000
		1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	ath Day	2000	3. Time of Death
Physicia		Josephine	Thelm	a		Jones		Septen	ber	4,2008	00:12a ^M
/Medica		4a. Facility Name (If not institution	, give street and number)			4b. City, Town, or	Location of Death		4c. C	ounty of Death	
		John Hopkins	Bayview Me	edical		Balt	imore				
Funeral			6. Sex 7. Ag	e (In yrs. last i	1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birthpl Count	ace (State or Foreign
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D .		Usual Residence of Decedent								140	lal Incide City Limite
rylar	_	10a. State 10b. County		10c. City, To	wn or Loc	ation					d. Inside City Limits 1X1Yes 2 □ No
a-f s	양	Maryland Cha	rles]	LaPlata	•				
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Count	ry?
th wi	<u>a</u>	300 Goose Cre	ek Drive			206				USA	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. I warked other than "natural", or Items 23a or 28a-f show umatic event, I's Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14	 Race - America Black, White, e 	
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led w lygie her t	ပိ	17. Father's Name (First, Middle,			Adm	<u>inistra</u>	18. Mother's Nam	o (Eiret Middle		Govern	ment
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2 sh n and r ls n		19a. Informant's Name/Relations		1		g Address (Street a					
and 2: Health a m 27 Is her trau		Lemuel Jones,	Son			Ocelot		Date		ation - City or To	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Examiner must be ruffilled at once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 ☐ Removal from State	1	-	sition (Name of natory or other plac				,	
. Pa tmen tant: jury		4 □ Donation 5 □ Other (S		Resi		ction				1 -0 -0 -0 -0 -0 -0 -0 -0 -0 -0 -0 -0 -0	aryland
permit. Departr Imports any inju		21. Signature of Funetal Service	dicensee			. Name and Addres	ra (al Home	
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		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	I the death. D ne.	o not ente	er the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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Examiner		Sequentially list conditions	bS€	PTIC	SH	OCK_			11	1 11	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	,				1//	1 10	2
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Attending Physician: The law requires that the death certificate. setor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	V		2:	3d. Date of delive Month	ery Day Year
dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant a			Other (specify)				MOHUI	Day 16ai
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i cian: Th certificate ector, pag		25. Was case referred to medical					26. Place of Dea			1 1 1 1 1 1 1 1	2 110
Physician: r this certifica ral director, p	o Be	examiner? 1 XYes 2 No	Hospital: 1 Inpati	ent 2 ER	/Outnatier	t 3 DOA Oth	OF'			Other (Specif	v)
J Phy er this	Certification: To	27. Manner of Death	28a. Date of Inju	ıry 28	b. Time of			28d. Describe			·//
th. : Afte	Ē	1 ✓ Natural 5 ☐ Pendin 2 ☐ Accident investig	g (<i>Month, Da</i> gation	ay, Year)	Injury		<br Yes 2 □No				
Atter dea ctor	fica	3 Suicide 6 Could	not be 28e. Place of Ini	ury - At home	, farm, str	eet, factory, office		28f. Location	(Street and	Number or Rura	l Route Number,
after after Dire	erti	4 ☐ Homicide determ	building, et	c. (Specify)				City or 10	iwn, State)		
spita ours neral		29a. Certifier 1 ☐ Certifyir	ng Physician: To the best	of my knowle	dge, deat	n occurred at the ti	me, date and place	, and due to th	e cause(s)	and manner as s	tated.
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner st		and/or in	vestigation, in my o	pinion, death occu	irred at the time	, date and	place, and due to	the cause(s)
orth o th	Me	29b. Signature and title of certifie	r			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
F > F O		1-12				RES	-000		09-	12-2005	7
		30. Name and address of person	who completed cause of	death (Item 23	a) (Type				O L	24	
BIL		30. Name and address of person	He 494	10 50	Sylven	N AVEN	IE RAL	100 -0 15	00	0 7-17	24
Sta	te.	31. Date filed (Month Day, Year)	32. Regist	rar's Signature	- 1 - 1	N AVENU	レッパー	TVICE	1		<u>-</u>
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Amend #25, perME, g884 10/29/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1tem 1 per doc g884 10-7-08 vt

State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend #8, perFH G884 10/10/08 Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sept 9,2008 **Physician** Josephine Kettering Kopp Josephine Kopp- Kettering 11:20pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House-Montgomery Hospice 8. Date of BirthSept. (Month, Day, Year) April 21,1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours United Kingdom 1 □ M 2 😾 F 291-28-7917 87 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Modeal Evain" or "nut by notified at MD Calvert Lusby 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 12873 Bay Drive 20692 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 🗷 No Specify. Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Magnee. College (1-4or 5+) Elementary/Secondary (0-12) Loan Clerk Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Bridge Anna Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kopp/ Son 12873 Bay Dr., Lusby,MD 20692 20b. Place of Disposition (Name of Park cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Pierce Brothers Mem | Sept 17,08 Westlake Village, CA 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility Joseph Gawler's Sons, INC uneral Service/Licensee all possiti 5130 Wisconsin Ave, N.W. Washington DC 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? yes 2 No 1 🗆 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) Hospice 1 Yes 2 XNo ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident a er dea in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral D completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a D0064615 Sept 10,2008

State Registrar

altimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Hospital

31. Date filed (Month, Day, Year)

Genevieve Wroblewski

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

PRILARY

6001 Muncaster Mill Rd, Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2008 Anne Kelley September 14, 12:55 % 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 7. Age (In yrs. last birthday) If Under 1Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Year) Months Days 1 □ M 2 🛣 F 15, 70 Sept. 1937 Washington, DC 217-32-3562 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 3310 N. Leisure World Blvd., #224

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Experiment at the market and once. Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

Director

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Joan

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

ending physician and use as the burial-transit signed by the a d be detached for certificate has within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2∑No	3. Was Dece If Yes, spe	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.
	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 ☐ x No Specify:		Specify: W	hite
completed by	15. Decedent's Ec (Specify only highest gra	ide completed)	16a. Decedent's Usi (Give kind of w life. DO NOT	ork done during most of w		16b. Kind of Busines	ss/industry
5	Elementary/Secondary (0-12)	College (1-4or 5+)	Office Ma			Insurance	
3	17. Father's Name (First, Middle, Last)				ame (First, Middle, M	Maiden Surname)	
	Leonard Groves			Emmie M	Marie Holm	berg	
	19a. Informant's Name/Relationship (Kathryn B. Davis	*' '		s (Street and Number or na Court, Or			, Zip Code)
	20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	ace of Disposition (Na emetery, crematory or of Heave		Sept. 18	20c. Location - City o	or Town, State
	21. Signature of Funeral Service Licer	isee	22. Name a Franc 500 U	nd Address of Facility is J. Collin niversity Bl	s Funeral	Home Inc	ing, MD 2090
	23a. Part 1. Enter the disease, or com shock, or fleart failure. List only Immediate Cause (Final	one cause on each line.		de of dying, such as card	iac or respiratory arro	est,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	Due to (or as a consequ	ence of:	APPEST			<u> </u>
	la construction of	50	20515				
1	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a nonsequ	ence cty:				
	triat iriitiated events	. Dv	T				
	resulting in death) Last	Due to (or as a consequ	ence of):				
		d					
ŀ	IF FEMALE:					1	
ı	23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		pregnancy		23d. Date of c	
	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant at time of de			· · · · · · · · · · · · · · · · · · ·	Month	Day Year
	9 ☐ Unknown Part II. Other significant conditions c	antributing to death but not requi	Iting in the underlying	aguag airen in Dart I	220 Did tok	acces use contribute	to the cause of death?
•	VIII VA D	On A ICCOO	iting in the underlying	cause given in Part I.			
	ANTALIC	CHIVLE 12			_ 1 L Ye	es 2/2/100 3 🗆	Probably 4 Unknown
-					24a. Was ai autops	v prior t	autopsy findings available o completion of cause of
					perform	med? death No 1 ☐ Ye	?
	25. Was case referred to medical examiner?				eath (Check only on	e)	
1	1 Yes 2 No	Hospital: 1 Impatient 2 E	ER/Outpatient 3 ☐ D	OA Other: 4 Nursing	Home 5 ☐ Reside	ence 6 ☐ Other (Si	pecify)
	27. Manner of De M 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, street, factor	y, office	28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
	29a. Certifier Certifying Ph	ysician: To the best of my knowniner: On the basis of examination and manner stated.	vledge, death occurred ion and/or investigation	d at the time, date and pla n, in my opinion, death oc	ace, and due to the courred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
-	29b. Signature and title of certifier		29	c. License number	2	9d. Date signed (Mo	nth, Day, Year)
	160		\ f	0064983	6	7/14/2.	
		completed cause of death (Item	22a) (Type Print)	(0)		11110	
	KAShif FIR	OZVI MD	2101 Me	dICAL PARI	L DRIVE.	SILVER SI	ORING MO 2090
	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	ure				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER D. **Physician** 2008 ROBERT JAMES KNOX 11:40P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE MITCHELL VILLE 11716 BISHOP CONTENT 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1፟፟፟∭ M 2□ F PENNSYLVANIA 77 205-20-7083 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show PRINCE GEORGE MITCHELLVILLE ¥ Yes 2 No MD Directo death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ed other than "natural", or items 23a or event, the Medical Examination between 20721 U.S.A. 11716 BISHOP CONTENT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: BLACK ۾ Yes. Give 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER ENVIROMENTALIST GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ESSIE HUNTER WILLIAM KNOX မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 11716 BISHOP CONTENT MITCHELLVILLE, MD 20721 ELIZABETH_KNOX/WIFE 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 🚻 Burial 2 🗆 Cremation 3 🗆 Removal from State FT. LINCOLN CEMETERY 09-13-2008 BRENTWOOD, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC PROSTATE CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner BONE METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physlclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day signed by the a d be detached for Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical



SEP 1 1 2008

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Registrar DHMH 17 Rev 1/2001 29c. License number

D43162

29d. Date signed (Month, Day, Year) 09-09-2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 1 I , 2008 **PEDRO** PABLO LUACES 9:41 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVIILE

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 1937
| Months | Days | Hours | Min. | June | 29,1937 MONTGOMERY Shady Grove Adventist Hospital 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Country) Cuba 152 M 2 □ F Director 262-04-4467 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Wodical Examiner must be northlised at Director 1 SYes 2 □ No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 Cuba 12399 Quail Woods Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? □ ∐Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Karyes 2 □ No Specify: Cuban Specify: Hispanic 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Auto Glass Mechanic Miles Glass Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leocadio Luaces Rosa Jimenez ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 is 1
any Injury or other traus 12399 Quail Woods Dr, Germantown, MD 20874 Diana Luaces (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 9/16/08 Hanover, MD 4 Donation 5 ☐ Other (Specify) Ardent Crematory 21. Si vature of Funeral Service Li. e > ee 22. Name and Address of Facility SNOWDEN FORERAL ROME, P.A. 246 N. Washington St, Rockville, MD 20850 3a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, schuthmia Immediate Cause (Final **Physician** minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disa to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. s been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Vascul Dhera 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy performe 2/A No 2 🗌 No 1 ☐ Yes 1 ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1/ Natural 5 Pending thin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Medical 29a. Certifier 1 🗹 Certifying, Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 9901 Medical Center Dr, Rockville, MD 20850 Orlee Panitch, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 15 2008 Registrar

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			1 - State Registra/AMEND#10d, 20c	perff, 9-15-	08,BMW,N	too Cer	tificate of I	Death	2. Date of De	Reg. No. 🗸 🔱	υŏ	3 093 3. Time of Death	
	Physicia	an	1. Decedent's Name (First, Middle, L		a				Month 5	Day	Year	1820 M	
ang.	/Medic		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of D		4c. County			
	Examin	ei	Howard Coun-	MG ener.	1 Ho,	pi tal	COLUN	nbia			vand		
	Funeral			Sex 7 1 □ M 2 ⊠ F	. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Min. (Month, Da	th ay, Year)	Cour		
	Director		579-74-9121 Usual Residence of Decedent						July,	23. 1921	Chin	a	
	ryland how	_	10a. State 10b. County Maryland Howard			, Town or Loc lumbia	ation				1	0d. Inside City Limits 1 Yes 2 No	
	ne Ma 18a-f s ptified	Director				Lambia	106 7:- 0-4-			10g. Citizen of	What Cour		
	with the a or 2 the not		10e. Street and Number 5086 Whetstone Road				10f. Zip Code 21044			USA	What Cour	ш у :	
	death ms 23	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S	S. 13. V		lispanic Origin	(Specify Yes or No uerto Rican, etc.))- 14. Ra	ce - Americ		
õ	after or ite		1 ☐ Never Married 2 ☑ Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	No No		Yes, specify Cuba	Specify:	uerto nicari, etc.;	1	ick, White, fy: Asia		
3	hours ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dat		16a Deced	ent's Usual Occup	ation		16b. Kind of 8			
<u>.</u>	in 72 n "nat	Completed	15. Decedent's (Specify only highest of	rade completed)	tor Eu	(Give I life. D	ind of work done of NOT use retired	during most of d)	working			,	
7	d with giene er tha	E O	Elementary/Secondary (0-12)	College (1-4	+01 5+)	H	omemaker				Home		
	be file Ital Hy d oth event	Be	17. Father's Name (First, Middle, Las Shao C. Chow	st)					Name <i>(First, Middle</i> Poo Chu	, Maiden Surnai	me)		
N Y	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, I'm Medical Evaminer must be notified at	မ	19a. Informant's Name/Relationship	(Type Print)		19h Mailin	n Address (Street	and Number o	r Rural Route Numb	ner. City or Towr	. State. Ziu	Code)	
2	s 1 and 2 should f Health and Mei ftem 27 is marke other traumatic		Mr. Yu Ling -						olumbia MD 2		,,,		
e,	ss 1 au of Hea Item		20a. Method of Disposition			lace of Dispos emetery, crem	sition (Name of patory or other place	Port C	Date 9-16-2008	20c. Location	- City or To	own, State	
Ĕ	Page ment ant: If		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Fo Fo	ort Line	oln Gemeto		7-10-2000	Brentwo	ood, M)	
Baitimore, maryiand z iz i 5-0035	permit. Pages 1 a Department of He Important: If Item any Injury or oth		21. Signature of Funeral Service Lic	ensee		u	Name and Addre	di Funer:	al Home, Ind Avenue, Sil	ver Sprin	ng MD C	20904	
			23a. Part 1. Enter the disease, or co	mplications that ca	used the death						16 110 2	Approximate Interval Between	
	Physician		shock, or heart failure. List on Immediate Cause (Final	ly one cause on ea	ch line.	La		2 (01)			7	Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (c	r as a consequ	uence of):	9	- (7)	, , , , , , , , , , , , , , , , , , , ,			9000	
	Examiner	۰	Sequentially list conditions,	b	r as a conse								
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
5	execu an and ial-tra	Exal	that initiated events resulting in death) Last										
g/60,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d									
ĕ	ertifica ding pl		IF FEMALE:	23c. If yes, outc	ome of pregna	ancu.				004 0	nan na dali		
ž	eath certific attending p for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2□ Feta ant at time of d	Ideath 3□	Ectopic pregnand Other (specify) _	у			ate of deliv Ionth	Day Year	
	the d	hysi	1 □Yes 2 ☑No 9 □ Unknown	9 ☐ Unkno			(-,, / -						
ν, T	w requires that the desteen signed by the should be detached	by P	Part II. Other significant conditions	s contributing to dea	ath but not rest	ulting in the ur	derlying cause giv	en in Part I.	23e. Did tobacco use contribute to the cause of death?				
0	require een si nould b	ted							_			bably 4 Unknown	
ပ် မ	e law i has b je 2 sh	Completed							— 24a. Was	s an 24b opsy ormed?	 Were aut prior to co death? 	opsy findings available ompletion of cause of	
<u>=</u>	siclan: The la certificate ha irector, page 2		25. Was case referred to medical					26 Place of	1 ☐ Yes Death (Check only	2 LH10	1 □ Yes	2 🗆 No	
5	Physiclan: this certific al director, I	o Be	examiner?	Hospital:	ipatient 2□	ER/Outpatien	t 3 □ DOA Oth		ng Home 5 ☐ Res		ther (Spec	ify)	
0	Attending Physician: If death. ector: After this certific by the funeral director, I	T:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o	f Injury n, Day, Year)	28b. Time of Injury	28c. Inju Wor	ry at 'k?	28d. Describe	how injury occu			
Division of Vital Records,	Attendii death. ctor: A y the fu	cati	2 Accident investigat 3 Suicide 6 Could not		of Injury At he	me form str	M 1 □ eet, factory, office]Yes 2□No		(Street and Nun	her or Ru	ral Route Number,	
<u> </u>	al or Attend after death Director: d	Certification: To	4 ☐ Homicide determine	ed buildin	g, etc. (Specif	y)	set, lactory, office		City or To	wn, State)	1201 01 1141		
	ospita hours uneral ly filler	<u>0</u>							place, and due to th occurred at the time				
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical	one)	and mann	er stated.	orr and/or In	vestigation, at thy	opinion, death	occurred at the time	20d Data size	and /Month	Day Year)	
	with Con	Σ	29b. Signature and title of certifier	M M	Ø		29c. Licens	se number		Sout Sign	ieu (ivionin	2002	
	4		30 Name and address of noveces with	no completed cause	of death (Item	n 23a) (Tvne	Print)			Jey.			
			29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person with the control of the certifier 31. Date filed (Month, Day, Year) SEP 1 5 2	dian le	7724	Little	- Patu	xent	Parkwa	y <01	umbi	a MD 2104	
	Sta	ate	31. Date filed (Month, Day, Year)	1000 32 Re	gistrar's Signa	ture	alf s			,			
	Registr	rar	SEL TO S	UUO MA	was so	A STATE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** M 2008 1:30P September Evelyn Mae Leapley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charles La Plata Center La Plata If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year Months Min 1 ☐ M 2 ☐ F Days Hours 92 ,1916 Washington DC Director 579-24-7711 June 11 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Neutroll Evanings must be notified at 1 Yes 2 No Director MD Charles La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 USA One Magnolia Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify Completed by White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Teller Bankins permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other to any injury or other traumatic event, In ones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Everett Lancaster Anne Allwine ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Leapley/Son 12225 Potomac View Dr. Newburg, MD 20664 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/15/2008 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10094521. Signature of Funeral Service Licensee 22 AREHART ECHOLS FUNERAL HOME, P.A. a. St. Mary's Ave. La Plata, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Arrhythmia /Medical Due to (or as a consequence of): Examiner Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Hypertension and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ned by the detached Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ZNo page 2 □ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After it filled in by the funera 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) -29c. License number 29b. Signature and title of certifier

Registrar

BB

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Crittenden, M.D.

SEP 15

31. Date filed (Month, Day, Year)

D0054547

7350 Van Dusen Dr. Suite 350, Laurel, MD

September 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 10, 2008 8:12a **Physician** September Morgan Mary /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) 04/05/1920 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Maryland 1 □ M 2 🔀 F 88 Yrs. 214-52-4453 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experience must be notified at 1X Yes 2 No Director Drayden Maryland St. Marvs 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20630 USA 46147 Jamm Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: Black 3altimore, Maryland 21215-0036 1 □Yes 2XINo Specify Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 1 and 2 should be filed wi Health and Menta! Hygien tem 27 is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Washington Price Agnes Claude ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 46147 Jamm Lane Drayden, Maryland 20630 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Ellen Jordan/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State __ 5 ☐ Other (Specify) 9/19/08 |Valley Lee,Maryland St. Marks Church 4☐ Donation 21. Signature 22. Name and Address of Facility Adams Funeral Home PA ery Service Licensee 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lief only one cause on each line. Approximate Interval Between Onset and Death HYPERTENSINE CARDIOVAS CHUAR DISEASE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of): attending physician a for use as the burial Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 L Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò KIDNEY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPOTHYROLDISM 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA 1∐ Yes 2∭ No Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? spital or Attending Phours after death.
Ineral Director: After ty filled in by the funers After 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 24 hours at Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier 9/10/08 ATTENDING PHYSIUMN

002

State Registrar 8700 CENTRAL AV H301

LANDOVER MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

garar's Signature

Physician Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed and within 24 hours after death.

Violetie Funeral Director: After this certificate has been signed by the attending physician Aomoletely filled in by the funeral director, page 2 should be detached for use as the burial director. P.O. Box 68760. Division of Vital Records,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 6, 2008 Marshall Frances 12:00 P M Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 101 Wesley Dr. #214 LaPlata Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign August 31,1929 Washington, DC Months Days Hours 1 □ M 2√13 F 579-32-9133 79 Usual Residence of Decedent 10h County 10c City Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 INo La Plata Maryland Charles Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 **USA** 101 Wesley Drive Apt. #214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Completed by Specify: White 3 Midowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Alice Joseph Francis Pepper Swann ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Post Office Rd., #306, Waldorf, MD 20602 Kimberly Marshall - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signaty of Funeral Service License ken 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final mid mo resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner eosciERotiz Due to (or as a consequence of): HILLDT DISITAL Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 X No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) Mellow CT WALDER SEP 1 1 2008

DHMH 17 Rev 1/2001

State Registrar

		1	For State Registrar	te of Maryland / Der. <i>Ce</i>	partment of He <i>ertificate of D</i>		Hygiene Reg. No	711118	31097
	Physicia		1. Decedent's Name (First, Middle, Last) SHANELLE MON	IQUE M	ÆDLEY		of Death th EMBER	5, 2008	3. Time of Death
1	/Medic Examin	_	4a. Facility Name (If not institution, give street PRINCE GEORGE HOSPITA		4b. City, Town, or I	ocation of Death		County of Death	RGE
	Funeral Director		5. Social Security Number 216-11-8658 6. Sex	7. Age (In yrs. last birthda 23 Yrs.	Months Davs	Hours Min. 8. Date (Mor	of Birth hth Pay Year 27-198	9. Birthpla Count 5 MARYL	ace (State or Foreign try) AND
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD PRINCE GEORG	10c. City, Town or LANDOVER	Location				0d. Inside City Limits 14 Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 7304 GOODLAND DRIVE		10f. Zip Code 20785		10g. C	itizen of What Count	.ry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Medical Experiment must be notified at	by Funeral	1 Never Married 2 Married	as Decedent Ever in U.S. med Forces? JYes 2 M No es, Give A ar or Dates:	3. Was Decedent of His If Yes, specify Cubar 1 □ Yes 2 ♣ No	spanic Origin? (Specify Yes , Mexican, Puerto Rican, e Specify:	or No- tc.)	14. Race - America Black, White, e	etc.
1215-0036	filed within 72 ho Hygiene. ther than "natur ont, I'm Wedien	Completed	, , , ,	oleted) (Gi life Illege (1-4or 5+)	cedent's Usual Occupa ive kind of work done di e. DO NOT use retired) LERK	tion uring most of working	16b. F	Gind of Business/Ind	ustry
and 21	d be filed vental Hygin ked other c event, I	Be	12th 17. Father's Name (First, Middle, Last) JOSEPH LEON MEDLEY			18. Mother's Name (First, TERRIE FLEET	Middle, Maide	n Surname)	
Maryland	1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than yther traumatic event, the My	P	19a. Informant's Name/Relationship (Type. Pr TERRIE F. MEDLEY/MOTE			nd Number or Rural Route DRIVE LANDOV			Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)			TERY 09-16-20	08 CLI		
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee		7474 LANDOV	s of Facility JB JENE VER RD LANDOV	ER, MD		E. Approximate
	death certificate be executed Exam de attending physician and dor use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to financial cause. Enter Underlying Cause (Disease or injury that initiated events	Se on each line. MYOCLONIC EPILES Due to (or as a consequence of): ACTIC ACIDOSIS Due to (or as a consequence of): 1.E.L.A. SYNDRON Due to (or as a consequence of):	PSY	g such as calculad of respir	and y direct,		Interval Between Onset and Death
0	the death certific y the attending pl ched for use as t	Physician/Med	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of delive	ery Day Year
rds, P.	law requires that the de as been signed by the a 2 should be detached t	þ	Part II. Other significant conditions contribut	ing to death but not resulting in th	e underlying cause give	en in Part I. 23		o use contribute to th 2 🙀 No — 3 🗌 Prob	he cause of death?
of Vital Records,	: The law requir cate has been s , page 2 should l	Completed					a. Was an autopsy performed? Yes 2	prior to con death?	ppsy findings available impletion of cause of 21 No
f Vita	ding Physician: The In. After this certificate hit funeral director, page	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hospit	1 Inpatient ZEFER/Outpa	atient 3 DOA Othe	4 Inursing Home 5	Residence		(y)
Division o	Attener deat ector:	Certification: To	1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day, Year) e. Place of Injury - At home, farm, building, etc. (Specify)	ry Work	í? Yes 2 □ No 28f. Loc	escribe how injustion (Street by or Town, Sta	and Number or Rura	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowledge, d On the basis of examination and/ound manner stated.	leath occurred at the tir or investigation, in my o	ne, date and place, and du pinion, death occurred at th	e to the cause ne time, date a	(s) and manner as s and place, and due to	stated. o the cause(s)
	Nithin Comp	Me	29b. Signature and title of certifier	rdersin	29c. License MD102			Date signed (Month, 08-2008	Day, Year)
	6)		30. Name and address of person who comple FRANCYN ANDERSON, M	0 3001 HOSPITAL		TERLY, MD 207	85		
ı	Sta Regist		SEP 1 1 2008 Year)	32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** 7:25 A. Elijah Mackall September 10, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5000 Lydianna Lane # 211 Suitland Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**∑**M 2□F 218-24-0338 Director 80 03/24/1928 Calvert Co., Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f short must be notified at XXYes 2 □ No Director Md. P.G. Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 Lydianna Lane # 211 20746 U.S.A. 14. Race - American Indian Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ediçal Examiner r e filed within 72 hours after d il Hygiene. other than "naturai", or item 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Black Specify. Specify: þ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation Truck Driver marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H 7 is marked ot Allen Mackall Helen Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: if Item 27 is any injury or other trau. Ollie V. Williams/Daughter 4413 Reamy Drive, Suitland, Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) :09/16/08 Suitland, Maryland Page 22 Name and Address of Facility & Sons Co., Inc. 21. Signature of Funeral Service Licenses 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician arcillena a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, issuing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the bunal-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 27 No 1⊟ Yes or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home 5 Residence 6 \(\triangle \) Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ို this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) SEP 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Mirca Alikhani, M.D. 11711 Livingston Road, Ft. Washington, Maryland 20744 Registrar's Signature

Registrar

4604

September 11,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month TAMES September6, 2008 19:15p M NEWMAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 12/26/1955 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1**X** M 2□ F Maryland 212-66-3470 52 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County 1X Yes 2 □ No Upper Marlboro Maryland Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 USA 10306 Pinemist Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married 1 □Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Board Elementary/Secondary (0-12) 12 College (1-4or 5+) Equipment Operator of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Butler Newman Sr. Mary James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20772 19a. Informant's Name/Relationship (Type. Print) <u>Lelia N</u>ewman/Wife Upper Marlboro, Maryland 10306 Pinemist Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 9/11/08 Clinton, Maryland Resurrection 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd.Aquasco, Maryland 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after death

3altimore, Maryland 21215-0036

the Maryland

/Medical

Director

Funeral

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Completed

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Physician/Medical Examiner þ Completed Be

cate has been signed by the page 2 should be detached funeral director, Certification: To

this certificate

After t

death.

2 Accident within 24 hours after death To the Funeral Director: 3 Suicide filled in by 4 Homicide

29a. Certifier (Check only

one) 29b. Signature and title of certifier

6 ☐ Could not be

and manner stated

29c. License number

1 ☐ Yes 2 ☐ No

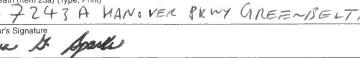
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and a lines of person who completed cause of death (Item 23a) (Type, Print)

247 A DAEE

State Registrar 31. Date filed (Month, Day, Year) 32. 15 2008



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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d by	3 Widowed 4 Divorced	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Army 1 ☐ Yes 2 🕱 No Specify: Specify: With the specify of the specify of the specify of the specific of									^{y.} Whi	te			
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To Be	Marion Nichols								Pilch			,			
۲	19a, Informant's Name/Relationship (7)	ype. Print)		19b. Mailin	a Addres	s (Street		<u> </u>	al Route Numl		or Town	. State. Z	ip Code)		
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iffica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At hom	ne, farm, str	et, factor	y, office			28f. Location	(Street a	and Numi	ber or Ru	ral Route	Number,	12.0
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	30. Name and address of person who co	ompleted cause of d	leath (Item 2	23a) (Type. I	Print)						(1	-	2 ,		
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Mary.	Examin		4a. Facility Name (If not institut		r)		4b. City, 7	Fown, or	Location of	f Death			unty of Death		
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	Funeral Director		5. Social Security Number 230–36–6849	6. Sex 1	Age (In yrs. la	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 11-10-]	ay, Year)	VIRG	place (State or F ntry) INIA	oreigi
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	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
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>	hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2 📜	R/Outpatie	nt 3 🗆 DO	A Othe	er: 4 🗆 Nur	rsing Hon	ne 5 ☐ Resi	dence 6 🗆	Other (Speci	fy)	
VISION OF	nding PI ith. : After the funeral	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pence 2 ☐ Accident inves	28a. Date of In ling (Month, E stigation	jury Day, Year)	28b. Time o Injury	of 28	Bc. Injur Work	yat <br Yes 2 □ N	2	8d. Describe				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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		For State Of Maryla		tificate of l			2000	31102
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/Med	cal	KICHARD, DELVIE	TR	4h Ciby Tourn or	Location of Death	09	4c. County of Death	1157
Exami	ner	4a. Facility Name (If not institution, give street and number)		01			01-06	10 Oraces
		5. Social Security Number 6. Sex 7. Age (in yr.	s. last birthday)	If Under 1 Year		. Date of Birth		place (State or Foreign
Funeral Director	A 100	215-62-0330 12M 2 F 5	7 Yrs.	Months Days	Hours Min.	Month, Day,	Year) Cou	aryland
		Usual Residence of Decedent				0124	/ / / / 210	ar y rana
yland		10a. State 10b. County 10c. 0	City, Town or Lo					10d. Inside City Limits
Mar a-f st	tor	MD Pr. Geo.	Mi	tchellv	rille			1 ∑Yes 2 No
h the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?
be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or flems 23a or 28a-1 show event, the Medical Exert at must be recitled at	a	1001 Arbor Park Place			0721		U.S.A.	
dea	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
or the		1 □ Never Married 22 □ Married 1 □ Yes 2 □ No 7	2-75	1 □ Yes 2 ☑ No	Specify:		Specify: R	lack
ours Frail,	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						
72 t	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	ient's Usual Occup kind of work done o DO NOT use retired	durina most of working	, 1	6b. Kind of Business/li Brinks l	
Page 1	I di	Elementary/Secondary (0-12) College (1-4or 5+)	iii e.	Salesma			Security	
filed within I Hygiene.		17. Father's Name (First, Middle, Last)		Datesilla	18. Mother's Name (First, Middle, M		У
ed la la	Be	John Rochester				a Patt		
fe, Malylal s 1 and 2 should be t Health and Menta item 27 is marked other traumatic ex	은	19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address /Street			City or Town, State, Z.	ip Code)
Md 2 shouth and 27 is m		Dorothy Patterson (Wife)		-			tchellvi	701/71
is 1 an of Heali	1.8		Place of Dispo	sition (Name of	Da		Oc. Location - City or 1	
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		natory or other place eran Cem		/08	Crownsvi	lle, MD
Dalling permit. Pages Department of Importent: If if any injury or of	1	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensine	. 29	Name and Addre	ss of Facility SNO	WDEN F	UNERAL H	OME PA
Department of the partment of		A Con 14 / In and les	1/2	46 N. W	ashingto	n St,R	ockville	MD 20850
SI SI STE		23a. Part1. Enter the disease, a complications that caused the de	101					Approximate
		shock, or heart failure. List only one cause on each line.						Interval Between Onset and Death
Physician /Medical	1	disease or condition resulting in death)	ocarc	hal	Intarc	non		
Examiner		Due to (or as a confs	equence or):					
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a const	equence of):					
lted Insit	무	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury the injurited events.						
exect n and ial-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consi	equence of):					
GOX COTOU, death certificate be executed e attending physicien and id for use as the burial-transit	cal							
VITAL MECONDS, P.O. BOX 00 of sicien: The law requires that the death certificate certificate has been signed by the attending physicator, page 2 should be detached for use as the								
ath cert	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fe	nancy	Ectopic pregnancy	,		23d. Date of deli	•
death	icla	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		Other (specify)	<u>'</u>		Month	Day Year
by the tache	hys	9 Unknown						
requires that the seen signed by the hould be detached.	by P	Part II. Dther significant conditions contributing to death but not r	esulting in the u	nderlying cause giv	ven in Part I.		acco use contribute to	
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The Tate has page	E O					perform	ied? death?	_
VILEI icien: 1 certifical ector, p	Be	25. Was case referred to medical	6		26. Place of Death	(Check only one	e)	
ysic ysic nis ce	To	examiner? 1 Yes 2/2 No Hospital: Inpatient	Eryburpaise	+ 3□ DOA Oth	ner: 4 Nursing Hom	e 5 🗆 Reside	nce 6 Other (Spec	city)
UNISION OF VITA For Attending Physicien: after death. Director: After this certific in by the funeral director,		27. Mannerof Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at 28 rk?	Bd. Describe ho	w injury occurred	
endin eath.	atle	2 Accident investigation		M 1 🗆	Yes 2 □ No			
r Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - Al building, etc. (Spe	home, farm, st cify)	reet, factory, office	28	Bf. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page								
Hosp 4 hou Fune	edical	29a. Certifier Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of exami	nowledge, deat nation and/or in	h occurred at the til vestigation, in my o	me, date and place, ar opinion, death occurre	nd due to the ca d at the time, da	iuse(s) and manner as ite and place, and due	to the cause(s)
the the	Med	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	se number	29	9d. Date signed (Monti	n, Day, Year)
5 × 5 8	1	M. Sarrara3i M.I.			48042		9/09/	
7			00-1					
		30. Name and address of person who completed cause of death (II	em 23a) (Type, 5 8 10	Valer.	in Laine	ROCKUI	16 MD Z	1852.
	ate	1 1 0 0 0						
Regis	tate trar	SEP 15 2008 Maries 2	nature	and I				
		OF: TO COOL MENTERS						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 1 - State Registrar #5 per fh, 9-17-08, eb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 30 PM David A1an Patterson 08 09 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico teninsula Regional Medical Xulisbury 9. Birthplace (State or Foreign 5. Social Security Number 196 If Under 1 Year | If Under 24 Hrs 8. Date of Birth 11–08–1925 7. Age (In yrs. last birthday) **Funeral** Min Months 82 Delaware Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10d. Inside City Limits 10a. State 10c. City, Town or Location Show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Extrained must be confined at one. 1XYes 2 ☐ No Director MD Somerset Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21853 11748 Mansion Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Scientist Naval Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gordon D. Patterson Ethel Beard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 11748 Mansion St., Princess Anne, MD 21853 Marian L. Patterson/wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 09/16/2008 4 □ Donation 5 □ Other (Specify) Salisbury, Maryland Salisbury Crematory Signature of Funeral Service Licensee Himan Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau e on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 ☐ Yes 2 ☐ No 3 🗓 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 2 No certificate 1 ☐Yes 2 ☐No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State
Registrar

1. Date filed (Montis Pays Year) 7 2008

32. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Septem Month UD **Physician** 2008 Parsons В. Serena /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner SMISBURY Wilcomico PENINSULA DEGIONAL MEDICAL CONTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 💢 F Maryland 214-30-9393 11-06-1933 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Madical Examiner mast by ny titled at 1 Yes 2 □ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 225 South Blvd. 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or iten any injury or other traumatic event, it a medical Evamina. 1 Never Married 2 Married 1 □Yes 2 No 3altimore, Maryland 21215-0036 Specify. Specify. þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 none Finance Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William F. Bozman Henrietta Carson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11518 Somerset Ave., Princess Anne, MD 21853 Hattie Sue Widdowson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Mt. Olive Cemetery 09-13-2008 | Westover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Service Licensee 22 Name and Address of Facility. Hinman Funeral Home M00295 11673 Somerset Avenue, Princess Anne MD 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Seps 15 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner acute exacev. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manyfer of Death 28b. Time of 28c. Injury at Work? After t or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: A Hospital completely

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifie

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

9/08

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SEPTEMBER NEWCORN 2008 4:00 ROSE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BRIGHTON GARDENS BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) 12/10/1927 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🖾 F Yrs MISSOURI 80 489-20-3194 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notfilled at tX Yes 2 No Director MARYLAND MONTGOMERY NORTH BETHESDA 10g. Citizen of What Country? 10e. Street and Number 20852 5550 TUCKERMAN LANE #321 IISA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ∏Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: ⋧ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JOURNALIST permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other I any Injury or other traumatic event, Ih 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be JOSEPH GRABER ADELINE NATHAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JEFFREY NEWCORN - SON 849 N. FRANKLIN ST #607, CHICAGO, IL Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p. NEW MOUNT SINAI CEMETERY 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State 4 ☐ Donation _5 NOther (Specify) ENTOMBMENT 09/15/2008 AFFTON, MISSOURI 21. Signature of Funeral Survice Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD Approximate Interval Between Onset and Death 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 3 YEARS OVARIAN CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed Exami burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown signed by t the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown cate has been sipage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 1 ☐ Yes 2 ☑No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1x Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of park n who completed cause of death (Item 23a) (Type, Print) CAROLYN BAIER O'CONOR, MD, 9715 MEDICAL CENTER DRIVE, SUITE #501, ROCKVILLE, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 1 5 2008 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMEND#23a(c)perMD9/24/08,BMW,McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** М 2008 1527 Audrey G. Smith September 11 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🖾 F Yrs 80 June 15, 1928 New Jersey Director 150-20-0133 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Experiment is tall be inclined at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Ves 2 No Director Herndon Virginia Fairfax 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20170 U.S.A. 875 Grace Street, #101 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🖾 No Specify δ Specify: 3 ₩ Widowed 4 Divorced Caucasian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen White Samuel Glick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9609 Pinkney Court, Potomac, Maryland 20854 Betsy Platt - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 09/14/2008 Judean Memorial Gardens Olney, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Hines-Rinaldi Funeral Home, Inc. Meelin 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PHULTI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Gram negative Physician: The law requires that the death certificate be executed Exami burial-tran Due to (or as a co P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 🗌 Yes 0 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Certification: To After this

09/11/08 1527PM

SMITH, AUDREY

Division of Vital Records, ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl filled in by To the Hosp within 24 hor To the Fune completely f

					1 □Yes 2 No	1 □Yes 2 □No		
25. Was case referred to me	edical			26. Place of Dea	th (Check only one)			
examiner? 1 ☐ Yes 2 No	Hosp	pital: Inpatient 2 🗆	ER/Outpatient 3 🗆 D	Home 5 ☐ Residence 6 ☐ Other (Specify)				
	Pending nvestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ C	Could not be letermined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	ry, office	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,		

29a. Certifie (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814

(Melissa Lynn Means, M.D.)

State Registrar

Medical

amend #19a Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Jean Ellen Skarnulis September 12, 7:10 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Holy Cross Hospital Montgomery Silver Spring 8. Date of Birth (Month, Day, Year) April 28, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1922 Washington, DC 1 □ M 2 🗓 F 86 579-18-0289 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2X No Director Maryland Prince George's Adelphi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20783 USA 23a 2402 Lackawanna Street death v Funera 14. Race - American Indian. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc within 72 hours after 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) uth and Mental F Be Mary Foley Eugene LeNoir ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other traus 19 Tuckahoe Road, Easton, CT 06612 Joan M. Welsh/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 22, Sept. 1 3 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner Bowel Necrosis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed -tran and physician ar s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö signed by the a d be detached f □Yes 2□No 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ þe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No this certificate 1 ☐ Yes 2 🙀 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🛣 No tx Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To eral n 24 hours at er death. he Funeral Director: A er th pletely filled i by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending I Division 1XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number 2 D D67589 September 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN RD., SILVER SPRING MD 20910 FOREST 1500 V.LAWSON 31. Date filed (Month, Day, Year) 32 egistrar's Signature State 1 5 2008 Registrar

08-07021 Glenn Swann

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 31108

			For State		Cert	tificate of	Death					eg. No.	. • •	0 0110	
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7	1.05		30. Name and address of pen	son who completed o	ause of death (Ite	em 23a)									
	MY		Donna M. Vincenti,		t Medical Exa		11 Penn	Street	t, Baltin	nore, M	D 21201				
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Director			XM 2 F 53	Yrs		ays Hours Min.	08/24/	1955	eign Country)VA
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Locat	ion				10d. Inside City Limits
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th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 409 South Jun	iata Street		10f. Zip Code 21 C		109	US	ountry:
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiens in Department is the Heath and Mental Hygiens in majoriant. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No			Hispanic Origin? (Spe an, Mexican, Puerto F		White, etc	
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	≥	29b. Signature and title of certifier	/ /		290. LIC	ense number		Zou. Date signed	(moini, bay, real)

OGME DB231

State 31. Date filed (Month, Day Year)
Registrar

DHMH 17 Rev 1/2001 OCME 2006 30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD. Deputy Chief Medical Examiner

2008

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

September 1, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:10 A M Jean Elizabeth Strang 9 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 5. Social Security Number Dice 8. Date of Birth (Month, Day, Year) 9/8/1929 Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 1 ☐ M 2 🔀 F Months Days 79 Yrs. 100-22-7364 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Hatteras St. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: <u>م</u> Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Readers Digest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Strang ပ္ Lillian Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Strang / brother 303 P<u>iedmont Ct., Ocean Pines, MD 2181</u>1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 9/16/2008 Frankford, DE 4 Donation 5 Dother (Specify) 21. Signature of Funeral Serviced 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Par 1. Enter the disease, or complicati Approximate Interval Between Onset and Death is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a.M.R.TASTATIC ADENO CARCINOMIT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of pate has been signed by the attending physician and page 2 should be detached for use as the burlal-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 □Yes 2 DNO the Hospital or Attending Physician: thin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Phpatient Certification: To eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Factifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02053410

Registrar
DHMH 17 Rev 1/2001

State

3 Hurrin

31. Date filed (Month, Day, Year)

BA 6

BOX 1733 SACis Bury on

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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SEP 1 6 2008

COASTIME HOSPICE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Maryland		tment of F ificate of			iene eg.No. 2∩∩	0 31111
		Decedent's Name (First, Middle, Last)					2. Date of Deat	th _	3. Time of Death
Physic /Med		Ida M. Sherwood					Septembe		3 12:15 PM
Exam	iner	4a. Facility Name (If not institution, give st				or Location of Death		4c. County of Do	
1 (V)		5. Social Security Number 6. Sex	1 Avenue 7. Age (In yrs. la	ast hirthday)	North E		8. Date of Birth	Ceci	L Birthplace (State or Foreign
Funera Directo	_		w 2 🕮 88	Yrs.	Months Days	Hours Min.	July 8	Year)	Country) elaware
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with with the r	ä	605 South Maryland	1 Avenue		21901			United S	·
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ther th	ပ်	11 17. Father's Name (First, Middle, Last)		Hor	nemaker	18 Mother's Nam	oo (First Middle	Own Home Maiden Surname)	9
Maryland nd 2 should be file lith and Mental Hy 27 Is marked oth	Be	John Maloney				Mary I		vialuen Gumame)	
should Me mark mark	2	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailing	Address (Street			r, City or Town, State	e, Zip Code)
Ma ind 2 safth au 27 Is		Joan Fitzgerald / 1	Daughter	605 S	outh Mar	yland Ave	enue, No	rth East,	Maryland21901
es 1 a of Hear I Item		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Re	20b. P	lace of Disposi	tion (Name of atory or other pla Memoria	(ce) Septe	Date ember	20c. Location - City	or Town, State
Fag ment ment lant: I		4 □ Donation 5 □ Other (Specify)	GI P					_	n, Delaware
Baltimore, permit. Pages 1 a Department of He Important: If Item any Injury or othe		21. Signature of Funeral Service Licenses		1				neral Home th East, l	e Maryland21901
STAGE		23a. P m1. Enter the disease, or complishock, or heart failure. List only one	tions that caused the death cause on each line.	n. Do not enter	the mode of dy				Approximate Interval Between
Physicia	_	Immediate Cause (Final disease or condition	Corona	ry F	rtery	Visa	las-e	_	Onset and Death UNKNOWN
/Medica Examine		resulting in death)	Due to (or as a consequ	uence of):					
		Sequentially list conditions, b.	Due to for as a consequ	uence of):					
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
\$8760, icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):					
68760, ificate be exe physician a sthe burial-	dical	d.							
a a a		IF FEMALE:							
death certified eattending	Physician/M	in the past 12 months?	 c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of department 	Ideath 3□	Ectopic pregnand Other <i>(specify)</i> _	су		23d. Date of Month	delivery Day Year
the de	ysic	1 ☐ Yes 2 📆 No 9 ☐ Unknown	9□Unknown	eau 5	Other (specify) _				
d hat better	by Ph	Part il. Other significant conditions cont	ributing to death but not resu	ulting in the und	lerlying cause gi	ven in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
Records, The law requires t the has been signed age 2 should be or	q pa						1 □ Y	es 2 <mark>X</mark> No 3⊡	Probably 4 Unknown
as bee	Completed						24a. Was a		autopsy findings available to completion of cause of
or Vital Rec Physician: The lav this certificate has al director, page 2:	E O						perfor 1□ Yes	med? deat 2XNo 1□`	1?
/ita	Be	25. Was case referred to medical examiner?					th (Check only or	те)	
or Vital Physician: Tr this certifical	은	1 ☐ Yes 2 No		ER/Outpatient	2 DOW			ence 6 DOther (S	Specify)
ng ng fter	ion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ork?]Yes 2∐No	260. Describe n	ow injury occurred	
Division of or Attending after death. Director: After din by the fune	ficat	3 Suicide 6 Could not be	28e. Place of injury - At ho				28f. Location (S	treet and Number o	r Rural Route Number,
Div tal or / rs after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify	y) 			City or Tow	n, State)	
Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		cian: To the best of my kno er: On the basis of examina and manner stated.						
To th within To th	Me	29b. Signature and title of certifier)	715	29c. Licen	se number	:	29d. Date signed (M	onth, Day, Year)
		Clamo		~) X	10056	4491.	9/10	5/08
6		Name and address of person who cor	1111 1111	23a) (Type, P	rint)	75	EIN	a ILID	21901
	tate	31. Date filed (Month, Day, Year)	32/Registrar's Signa	ture /	JT. D	uite 26	CUM		110/
	tate	SED 1 7 200		K Kos	42)				

DHMH 17 Rev 1/2001

Sherwood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Emil. Μ. Sowards 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PANINSULA DEGIONAL MEDICALCENTER WICOMU 18BUR If Und 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** 6/10/1934 Year) Days Months Hours Min. 225-36-3670 Director 74 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Medical Examination at 1K∐Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with USA 21804 304 Prince Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married If Yes, Give Year or Dates: Air Force 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. 9 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Cinda Adams Carl Maggard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a mit. Pages 1 and 2 partment of Health a cortant: If item 27 is / injury or other tra 624 Ampthill Rd. Cartersville, VA 23027 Katherine Baber/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If any injury or once. 10/01/2008 Arlington, Virginia 21. Signature of Funeral Service Licens Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last neumonia Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy р Month Day Ye ar signed by the a d be detached fo 5 Cher (specify) P.O. ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 V Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy perform certificate 1 □ Yes 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) nours after death.

neral Director: After this ce
y filled in by the funeral dire Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 00067738 2111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll St. Salisbury MD. 21801

Registrar DHMH 17 Rev 1/2001

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egistrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) Physician 09/12/2008 11:15 PM HAROLD T. SHRIEVES /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Wicomico 613 Oak Hill Ave. Salisbury 7. Age (In yrs. lest birthday)

64 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 08/17/1944 5. Sociel Security Number 215-44-3842 Birthplace (State or Foreign Country) **Funeral** Months Deys 1**X** M 2□ F VA Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 □ No Director Wicomico Salisbury MD 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 613 Oak Hill Ave. 21801 USA Funeral Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Henry Shrieves Flossie Trader Shrieves ဥ 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Barbara Shrieves, Spouse 613 Oak Hill Ave., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Department of important: If it 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/20/08 Mappsville, VAFirst Baptist Cemetery 21. Signature of Funeral Se 22. Name and Address of Facility Cooper & Humbles Funeral Co., Accomac, VA 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Physician Adonocercuroma & lung Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 □ Nursing Home 5 Presidence 6 □ Other (Specify) Medical Certification: To 1 Yes 2 No fillad in by the funeral 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 24 hours eftar deet Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the I within 2 29d. Date signed (Month, Day, Yeer) 29c. License number

Registrar DHMH 16 Rev 6/95

State

Division of Vital Records, P.O. Box 68760.

erson who completed cause of death (Item 23e) (Type, Print)

egistrer's Signeture

9/15/08

Salubuny no 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04, 2008 Physician Sept. 1649 P M Joseph Tunsta11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 6, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 81 1926 Mississippi 412-40-6468 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f show event, the resolved Evanturer must be notified at 17 Yes 2 No Director Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901-1013 U.S.A. 10902 Fiesta Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 Mayes 2 □ No If Yes, Give 1945 Year or Dates: 1946 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify ģ Specify: Black 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hyglene. College (1-4or 5+) 5years Elementary/Secondary (0-12) Accountant SBA Private is 1 and 2 should be filed with Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward John Annie Griffin ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Sue Freeman Tunstall/wife 10902 Fiesta Road, Silver Spring, Md. 20901-1013 Department of Health Important: If item 27 any injury or other troops. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition Pages 1 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Maryland National Sept. 3831 Georgia Avenue, N.W. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 278 Latney's Funeral Home Washington, D. C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** End stage renal disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit death certificate be executed Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Coronary artery disease autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ₩ No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After the Completely filled in by the funeral 28c. Injury at Work? 5 ☐ Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

Registrar

Alan R. Segal MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Forest Glen Road, Silver 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500

DHMH 17 Rev 1/2001

29c. License number

D52261

Spring Maryland

29d. Date signed (Month, Day, Year)

Sept. 4, 2008

			For State Registrar	State of Ma	aryland / Dep	artment o		nd Mental Hy	ygiene Reg. No. 2 N N S	0 01116
	Physici /Medic		Decedent's Name (First, Middle, Last THOMP SON	TON				2. Date of D Month	eath Pay Year	3. Time of Death 5 45 P M
400	Examir		4a. Facility Name (If not institution, give CIVISTA MEDICA	IL CENTE	-R	LA	n, or Location of D PLATA par If Under 24		4c. County of Dea	FS
	Funeral Director		5. Social Security Number	ex 7. Ag	e (In yrs. last birthday 71 Yrs.	Months Da		Min. 8. Date of B	9. Bi 29, 1937 SOU	rthplace (State or Foreign Jountry) TH CAROLINA
	e Maryland 8a-f show tiffed at	ctor	10a. State 10b. County MD PRINCE (GEORGE	10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th 23a or 24 ust be no	Funeral Director	10e. Street and Number 4910 DUBLIN DRIVI	Ξ		10f. Zip Cod 20746			10g. Citizen of What C	Country?
920	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Mackeal Ensaminer must be notified at		11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ∰Yes 2 ☐ If Yes , Give Year or Dates:		Was Decedent If Yes, specify 0 1 ☐ Yes 2 ☐		n? (Specify Yes or N Puerto Rican, etc.)	Specific	
Baltimore, Maryland 21215-0036	within 72 ho iene. • than "natur he "edeal	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or t	(Giv 5+)	edent's Usual Od e kind of work do DO NOT use re R CONDI	one during most of tired)	f working	16b. Kind of Business	······································
/land 2	should be filed and Mental Hygi s marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) THOMPSON H. TONEY				18. Mother's ELLA W		e, Maiden Surname)	
, Mary	d 2		19a. Informant's Name/Relationship (CORINIA P. TONEY)		4910	DUBLIN	DRIVE S	UITLAND,		*
timore	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)		AN CEME	TERY 09	Date -17-2008	20c. Location - City o	, MD
Bal	permi Depa Impo any it		21. Signature of Funeral Service Licer 23a. Part 1. Enter the disease, or com	hall	/ 7	474 LAN	DOVER RD	LANDOVER	S FUNERAL H	OME Approximate
	Physician //Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	and ancies on angle II					diseave	Interval Retween
8760,	icate be executed physician and physician and the burial-transit	dical Examiner	Sequentially list could be if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):	r wit	4 Met	astatic	diseave	months
P.O. Box 68	ath certif attending for use as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	☐ Ectopic pregr ☐ Other (<i>specif</i>			23d. Date of d Month	elivery Day Year
rds, P	w requires that the de been signed by the should be detached	ed by Pr	Part II. Other significant conditions of		out not resulting in the	underlying cause	e given in Part I.		l tobacco use contribute] Yes 2 □ No 3 □ I	to the cause of death? Probably 4 💢 Unknown
Division of Vital Records,	The law recate has being page 2 sho	Complet				-		24a. Wa aut per 1 🗆 Yes	opsy prior to formed? death?	autopsy findings available o completion of cause of es 2 □ No
Vit.	ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 [VInpati	ent 2 ☐ ER/Outpatio	ent 3 □ DOA	Other:	f Death <i>(Check only</i> ing Home 5 ☐ Re	one) sidence 6 □Other (Sp	necify)
sion of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director. After this certificate hat completely filled in by the funeral director, page.	Certification: To	27. Manner of Death 1	28a. Date of Inju (Month, Da	ury 28b. Time	of 28c.	Injury at Work? 1 □Yes 2 □ No	28d. Describe	e how injury occurred	
Divis	ital or Att urs after de ral Directe		3 ☐ Suicide 6 ☐ Could not be determined	building, et	ury - At home, farm, s c. <i>(Specify)</i>			City or To	(Street and Number or I own, State)	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical			of examination and/or				ne cause(s) and manner e, date and place, and di	
		Me	29b. Signature and title of certifier R. Sund	word			cense number -61614		29d. Date signed (Mor	nth, Day, Year)
	100)		30. Name and address of person who RAVINDER K. SINDH	completed cause of o	Weath (Item 23a) (Type	, Print) FFICE	ROAD SU	TE 101 1	WALDORF, M	0 20602
	Sta Registr		31 SEP I 1 2008 Year)	32. Registr	rar's Signature			<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 13, Physician JOANNE 2008 TRAPANE 1:28 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F California 1937 556-50-7918 71 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evan Internation and Dece. 1 Yes 2 □ No Directo Maryland Frederick Thurmont 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20 Elm Street 21788 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 2 Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Monroe Frances Bryant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rich Trapane / Son 4 Todd Ct. Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Sept. 14, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Resthaven Crematory 4 Donation 5 Other (Specify) 2008 Frederick, Maryland Resthaven Funeral Services, Skkot Cody PA 21. Signature of Funcial Service Licensee 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part. Enter the disease, o shock, or leart failure. List Immediate ause (Final disease or condition resulting in death) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Physician Bacteremia E. Wil /Medical Due to (or as a consequence of) Examiner days Probable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 OPD, Hypertension, Myperlipidem 1 4 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 NO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Hospital or Attending 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 29a. Certifier 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

DHMH 17 Rev 1/2001

Registrar

MDD 66166

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MA

2008

32. Registra's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400~West~7th~Street,~Frederick,~MI

·Kerza

SEP 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 3:57 PM Herman Leon Wagner September 09, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1₺ M 2□ F **Director** 057-14-4262 87 March 21, 1921 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Machael Experiment in 1st be notified 31 once. 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3210 N. Leisure World Blvd., #505 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: \$ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physical Chemist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Max Wagner Regina Hahn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Wagner - Spouse 3210 N. Leisure World Blvd., #505, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 09/14/2008 Olney, Maryland 21. Signature of Funeral Service Liq 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in I 24 hours a 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number

State

31. Date filed (Month, Day, Year) SEP 1 5 Registrar



2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** М SEPTEMBER 15, 2008 WAYNE DAVID WICKER 1709 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. OCTOBER 1° 1944 1 M 2 □ F 63 PENNSYLVANIA 169-36-6113 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Evantment must be notified at once. 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2 No QUEEN ANNE'S CHESTER MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 DUNDEE AVENUE UNITED STATES 21619 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married timore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **SUPERVISOR** CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ CHARLES LOUIS WICKER FLORENCE ESTER WYNKOOP 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN BERNADETTE WICKER/WIFE 108 DUNDEE AVENUE, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION
CENTER SEPTEMBER 16 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 STEVENSVILLE, MARYLAND FELLOWS 106 22. Name and Address of Facility FEI FUNERAL HOME, P.A., SHAMROCK ROAD, NEWNAM CHESTER Licensee MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart fa at caused the death. on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No. the 9 Unknown þ icate has been signed, page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 □ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Medical Certification: To 1 ☐ Yes 2 **□** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation atural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide Hospital 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, P/int) 31. Date filed (Month, E Day, Year) Registrar's Signature State

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 00:02 M Rosie B, White OY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Battimore, IND BaHimore of maryland Medical Cert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jun∈ 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Hours Georgia 256-32-8096 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Noticel Examinational to rediffed at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 XYes 2 No Director MD Prince George's Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20705 U.S.A. 11807 Heartwood Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: δ 3XDWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fate Prince Terry Hunt ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Lee White, Sr./son 11807 Heartwood Drive, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages
Department of
Important: If it
any Injury or o 1 Burial 2 □ 3. ☐ Removal from State MD National Cemetery 9/13/2008 Laurel, MD 4 Donation 5 □ Other (Specify) Signal of Funeral Service Libera 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 Approximate Interval Between Onset and Death 23a. Partif. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cordiovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 Other (specify) P.0. 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mouton, M.D. 18165

Registrar

Greene Si.

Baltimore

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S.

Morton

Tiffany

Date filed (Month, Day,) SEP 1 1 2008 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	Department of Health and Menta	l Hygiene
			1 = State Registrar	Certificate of Death	Reg. No. UU8 3112U
	Physici /Medic			Mor	28 2008 d por
-	Examin		4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
				W. PRANKLY ST. BALTIMORE A	
ı	Funeral Director		218-12-6457 1DM 20F 87	Yrs. Months Days Hours Min. 2 -1	o of Birth, nd. Day, Year) 9 - 2 9. Birthplace (State or Foreign Country) NC
	and w			own or Location	10d. Inside City Limits
	Maryi f sho	to	MD N/A Bal	ltimore	X□Yes 2□No
	r 286	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a c	a D	1643 Wadsworth Way	21234	USA
	tems	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 	s or No- stc.) 14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show he Madisal Evanther nual be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No II Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	African ^{Specih} American
9	2 hou	ted	15. Decedent's Education 16	5a. Decedent's Usual Occupation	16b. Kind of Business/Industry
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121	filed with Hygien sther the soft, the			Taxi 18. Mother's Name (First,	Middle Maiden Sumame)
Maryland 21215-0036	d a b w	To Be	17. Father's Name (First, Middle, Last) Samuel Knotts	Mattie Kno	
lary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rural Route	
	s 1 and 2 if Health item 27 other tra		Edward N. Rucker/grandson	1643 Wadsworth Way,	20c. Location - City or Town, State
יסר	t of tf it		20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State	of Disposition (Name of Interpretation) (Name	Balt.,MD
Baltimore,	교육 변경		'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Structure Company	22. Name and Address of Facility Hari F	Close F Sys PA
Ba	perm Depa Impo any i		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	5126 Belair Rd, Balt	.,MD 21206-5105
760,	Medical Examiner while partial transit he purial transit	ical Examiner	d	ee of):	n Chronic
P.O. Box 68	The law requires that the death certificate the has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
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Records,	w requir been si should	Completed by	Diaboles wellitus, Co		
Rec	has l	mpi	Hypothyrocolesm,		autopsy prior to completion of cause of death?
Vital		e Co		26. Place of Death (Chec.	Yes 2 No 1 Yes 2 No
N	Physicien: this certificated rail director, I	ToB	examiner?	011-1-	□ Residence 6 □ Other (Specify)
n of	문 는 Fe			Injury Work?	scribe how injury occurred
sio	tend leath tor: the	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	cation (Street and Number or Rural Route Number,
Division	al or Attences after death	Certification;	3 ☐ Suicide determined determined determined determined building, etc. (Specify)	rarm, street, factory, office	y or Town, State)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (dge, death occurred at the time, date and place, and due and/or investigation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
	within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1		MONT M.D.	00017202	7/29/08
ł	H		30. Name and address of person who completed cause of death (Item 23a		,
	\ 	10	Date Clark (Month Care Vone) 20 Denistrade Cinnettics	WELENA AVE BAL	TIMORE MD 2/222
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SEPTEMBER 24 2008 **Physician** 12:45P ^M ADELMAN GERTRUDE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 96 214-01-0903 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b Count show ed other than "natural", or items 23a or 28a-f show event, the Wadical Evaminer must be notified at 1 Tyes 2 No Director MD MONTGOMERY ROCKVILLE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 6111 MONTROSE ROAD, APT. #1018 20852 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No WHITE If Yes, Give Year or Dates: Specify. Specify: Completed by 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ENGLE** MINNIE ZUCKERMAN ABRAHAM ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other traisonce. 3805 INGLESIDE STREET, OLNEY, MD EVELYN DEITCH / NIECE Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 09/28/2008 BALTIMORE, MD WORKMEN CIRCLE 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Scott 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HRONIC STRUCTIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t To the Hospital or Attending I within 24 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30_ Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE R ESH 20852 MO NO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP30 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Belcastro Sr. W. Michael /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner er 1 Year | If Under 24 Hrs. | Hours | Min. Baltimor 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 XM 2 □ F Months 213-07-4216 June 24,1917 Italy Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 ia marked other than "natural", or items 23a or 28a-f show traumatic event, The Medical Eventine in ust be notified at 1 ☐Yes 2 XNo Funeral Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2763 Kirkleigh Road 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 years Foreman Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Belcastro Rose Ferrie ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Armstrong Lane, Pasadena, Maryland 21122 27 Michael W. Belcastro Jr. son permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 3, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Dundalk, Maryland 2008 21. Signature of Fune al Service Licensee Conneily Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk,MD. 21222 23a. Part 1. Enter the disease, o complications that caused the death. shock, or heart failure. List or y one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): physician s the burial 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use ontribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 MNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Marrier of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be

Physician: The law requires that the death certificate be executed P.O. Box 68760, been signed by the attending p should be detached for use as Division of Vital Records, s certificate has I lirector, page 2 s After this Hospital or Attending

death v

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

within 24 hours after death. To the Funeral Director: completely filled in by

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

29b. Signature and title of certifier

SEP 3 0 2008

Dr. M. FAWAD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

d Cause of Carlot Grant Carlot r. Muhammad Fawad ,9000) Franklin Square Dr. Baltimore, 4D 21237 Date filed (Month, Day, Year)

Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day & **Physician** ALBERT BERGER 12130M eptember 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** medical Cente OHNS HOPKINS BAYVIEW BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, March 30, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Days Hours Maryland 217-24-0222 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits show items 23a or 28a-f sh wr roust be notified Funeral Director 1 ☐ Yes 2 XNo Maryland Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1207 Ridgeshire Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \mathbb{X} Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify other traumatic event, the Medical Exag-<u>}</u> 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years Police Officer Baltimore City and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert M. Berger Helen Thornton ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Cynthia Bohle 417 1/2 Cedar Hill Road, Brooklyn Park, MD. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Pages 1 Department of H Important: If ite any injury or ot once. September 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 29, 2008 Baltimore City, MD. Signature of Juneral Service Lice 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Part 1. Enter the disease, or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Renai Failure day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner lumonia Weeks Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No 1 TYes 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ours after death. neral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

31. Date filed (Month, Day, Year) SEP 3 0 2008

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29b. Signature and title of certifie



MI).

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

idhaye

EASTERN AVENUE

1)60186

BALTIMORE, MD 21244

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Brown eanette 0640 2008 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPICE Baitimore JOHNS HORKING BAYVIEW MEDICAL CERTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 216-26-13 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** -26-7371 1□M 2XF 9 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Bactimor Director 1 No 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA or Items 23a Elber1 2122 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 WNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Black þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. CARE Elementary/Secondary (0-12) College (1-4or 5+) CARE NIA other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H le marked otl Ernest Brooks Threat Nannie Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 le any injury or other trau -sister 3311 Elber 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 9-29-08 ¹ 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility 270 F 21. Signature Funeral Service Licens 1 P. March Fitt. 23a. PHI1 En showk, o r the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Immedi ue ause (Final disease or condition resulting in death) Onset and Death Physician dementia /Medical Due to (or as a consequence of): **Examiner** Cerebravascular Jyear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No performed Ivision of Vital 2 No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient P 1 ☐ Yes 2 ☐ A Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA s after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1008 32. Registrar's Strature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month SCOT. **Physician** BARNES 3:52 AM 200 2 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ANNE MOTPHIHZAW FLEN BURNIE ARUMDEL HOSP 8. Date of Birth (Month, Day, May 5, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 A M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. Maryland 213-36-3092 69 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show be filed within 72 hours after death with the Marylar that Hyglene.
other than "natural", or items 23a or 28a-f shov event, the Marylar chilled a worth. 1 ☐ Yes 2 X No Director Pasadena Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21122 8142 Bodkin Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
N/A Elementary/Secondary (0-12) Westinghouse Welder 11 and Mental Hygle is marked other t 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Elsie Amelia Agnes Albert Barnes Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1513 Puffin Court Pasadena, Maryland 21122 Thomas W. Barnes (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Brooklyn, Maryland Cedar Hill Cemetery 10/03/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCTT1Ty → P619fiTak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OMFESTIVE HEART YGARC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 10 YEARS Examiner MAHYSEMA Sequentially list conditions, if any, leading to hinne liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) physician the buria Physician/Medical signed by the attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

certificate be executed Box 68760, P.0. Division of Vital Records, To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Maryland 21215-0036

Baltimore,

Medical

t

GEORGE 31. Date filed (Month, Day, Year) State SEP 3 0 2008 Registrar

29a. Certifie

(Check only one)

29b. Signature and title of certifier

29c. License number 10059190

≠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29, J 003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAFFOE-BONNIE, BALTIMORE WASHINGTON HOSPITAL. GLEN BURNIE

32. Registrar's Signature

			1 – For State Registrar		ryland / Depa		Health and M	lental Hyg	3	8 3112
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, La Patricia 5 Ba 4a. Facility Name (If not institution, giv Johns Hopkins Day	a Ker re street and number)	(enter	4b. City, Town, o	r Location of Death	2. Date of Death Month	Day Year Year Ac. County of De.	1950 P M
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Feb 28,	N/A Year) 9. B 1941 Ma:	irthplace (State or Foreign Country) ryland
1	be lied within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm "Madical Examina must be natified at	Director	10a. State 10b. County Maryland Anne Ar 10e. Street and Number		10c. City, Town or Lo		ısadena	11	0g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
1	ns 23a or	Funeral Di	234 (ircle Road			21122		USA 14. Race - Arr	
9800	o within 7.2 hours after death with the Marylar glene. glene. than "natural", or items 23a or 28a-f show the "madical Exprine must be notified at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 👿 N If Yes, Give Year or Dates:	0	1 □Yes 2 X No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:		Black, Wh	white
21215-0036	e filed within 72 at Hygiene. other than "nat vent, the Moder	Completed	15. Decedent's E. (Specify only highest grant property of the secondary (0-12)	ducation ade completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired memaker	oation during most of workir d)	ng	lousewife	·
Maryland	permir. Pages I and 2 should be lied Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I once.	To Be	17. Father's Name (First, Middle, Last John Herbert				L	ine Emma	Dashner	
e, Mai	l and 2 sr Health and Sm 27 is n ther traun		19a. Informant's Name/Relationship (Charles Morgison	Type Print) Baker (Hus	sband) 234	Circle	Rd., Pasa	adena, M	ld. 21122	
Baltimore,	nt. Fages rtment of I rtant: If ite		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	y)	20b. Place of Dispo cemetery, crer Glen Have	en Mem Pk	10/2/	/08 G		e, Maryland
Bal	Depar Impor any ir		21. Signature of Funeral Service Licer			3204 Moun	olyniakFur tain Rd.,	Pasaden	a, Md. 21	
	hysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Legaria	ine death. Do not ent e. O Pailo consequence of):		ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
760, 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	sician and sician and purial-transit	cal Examiner	Sequentially list conditions, if my learning in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Liver Fa	consequence of):					6 months
vision of Vital Records, P.O. Box 687	S > 0	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	гу		23d. Date of d Month	elivery Day Year
rds, P	n signed b	d by Pl	Part II. Other significant conditions of	ontributing to death but	t not resulting in the un	nderlying cause giv	ren in Part I.			to the cause of death? Probably 4 Unknown
al Reco	certificate has been ector, page 2 should	Completed						24a. Was ar autops perform 1 □ Yes 2	y prior to ned?, death?	autopsy findings available completion of cause of s 2 No
of Vit	this certiral directo	: To Be	25. Was case referred to medical examiner? 1 Yes 2 100 27. Manuaer of Death	Hospital: 1 Inpatier	nt 2 ER/Outpatier		4 Li Nursing Hon	ne 5 ☐ Reside	nce 6 ☐ Other (Sp	ecify)
Division of Vital Records,	within 24 hours after death. To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should	Medical Certification: To	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day,	Year) 28b. Time of Injury ry - At home, farm, street (Specify)	M 1 🗆	Yes 2 □ No		w injury occurred reet and Number or F , State)	Rural Route Number,
Div	in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 1 ☑ Certifying Pr 2 ☐ Medical Exar	ysician: To the best of niner: On the basis of and manner state	examination and/or in	n occurred at the til vestigation, in my c	me, date and place, a opinion, death occurre	and due to the ca ed at the time, da	ause(s) and manner ate and place, and du	as stated. ue to the cause(s)
اً ا	With To 1	2	29b. Signature and title of certifier			29c. Licens			Od. Date signed (Mor	
	5		30. Name and address of person who thlaw Roubins L	1940 Easter	m Avanue		ore, manil	and 212	24	
	Sta Registr		31. Date filed (Month, Day, Year) \$\hat{SEP} \hat{3} 0 201	32 Registrar	's Signature	وينكه				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SEPTEMBER 25, 2008 **Physician** 6:40 A MYRTLE BERNICE BLACK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examine FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 257 F 26, 1922 North Carolina Feb. Director 86 238-30-5188 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21K No Director Maryland Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21050 USA 109 Forest Valley Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No 2 Specify 3 XWidowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Shoe Manufacturing 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Caroline Andrews ပ Jessie Mac Toliver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau 3433 Dublin Rd., Darlington, MD 21034 Norma Daniels / Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cre 3 Removal from State ther (Specify) 4 □ Donation 5 Bel Air Memorial Gdn 9-27-08 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. e of Fun 50 W. Broadway, Bel Air, MD 21014 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Part1 Enter the shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the origing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an autopsy perform certificate 1□ Yes 2□No Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D32295 Seprember 26, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP30 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 8:10 PM 08 Grace S. Brice 9 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Posedale Franklin Square Hosoita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV. 11, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours ^{Year)} 1909 Months Days Min. 1 □ M 2 □ F 220-01-6079 98 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Worldal Ever, inser result be notified at 1 ☐Yes 2 ☐No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14 McCormick Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: <u>\$</u> Specify: 3 X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker / Volunteer Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Steward Laura Mobley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Beretta Way; Bel Air, Nancy Jones daughter MD21015 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) Hilltop Service Corp. 9/29/08 Towson, MD 4 Donation e/Service/L 21. Signature of Fi 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comshock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DY DY DY V AYTEYU /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or se's conesquence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been sfuneral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 🛛 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DOING H. WOLDEHWOT D0063327 Sept. 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIZAW WOLDETTIWOT, MD GODO Franklin Square Drive Balhmore MD 21237 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 3 0 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Mason Anthony Clift, Jr. September 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice, Dove House Westminster Carroll | West Litter | State of Birth (Month, Day, Year) | Oct. 10, 19 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** ХХМ 2□ Б 213-32-0866 73 Yrs 1934 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show Director Maryland | Carroll Hampstead 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code "natural", or items 23a or 2650 Old Fort Schoolhouse Road Funeral 21074 of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Westinghouse Electric Elementary/Secondary (0-12) College (1-4or 5+) 4 <u>Electrical Engineer</u> Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental File is marked ott es 1 and 2 should be of Health and Menta item 27 is marked Mason Anthony Clift Frances Elmore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol S. Clift (Wife) 2650 Old Fort Schoolhouse Road, Hampstead, MD 21074 Saltimore, 20b. Place of Disposition (Name of Sep. 30, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any Injury or otl Greenmount Church 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Cemetery Greenmount, Maryland 21. Signature of Fun in Sea ce in a 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A.
3296 Charmil Drive, Manchester, Maryland 21102 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death h ek, or heart faili Physician cerebrovascular /Medical Due to (or as a consequence of) Examiner Demank Sequentially list conditions, if any, leading to him equate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine be executed and Due to (or as a consequence of) Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No o. the 9☐ Unknown 9 I Inknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 130x 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform rmed? 2 **X** No certificate or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6XOther (Specify) Dove Howe Hospital: 2**X**No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After **Division** 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) SEP 3 0 2008

29b. Signature and title of certifier

Dunewilla, mo

30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print) R . F. ANSURIYA 349 Maccolm DR 2. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D 51705

Westmirston

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** September 26, Ann Baker Cuenin 2008 9:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 6004 Osceola Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 🕅 F 89 Director 283-14-9198 Feb. 15, 1919 Ohio Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show Department of Health and Mental Hygiene. Important; if item 2.28 or 28a-f show amounts, if item 2.7 is marked other than "natural", or items 2.8a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be retified a once. Director 1 ☐ Yes 2 🔀 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6004 Osceola Road 20816 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed withIn 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No <u>م</u> Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Broadcasting Journalism 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley Baker Anna Joyce ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Vogel/Daughter 6004 Osceola Road, Bethesda, Maryland 20816 20a. Method of Disposition 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Oct. 7, 2008 Arlington, Virgina 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M01548 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Breast Cancer to Bone disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed and Due to (or as a consequence of): burial-1 Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) P.O. the detached 9 ☐ Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? nas autopsy performed' certificate 2 🛛 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient this မ 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person v

Carolyn Hendricks,

Year)

Caroly...
31. Date filed (Month, Day,

no completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

M.D.,

License number

D37236

6410 Rockledge Drive, #506, Bethesda, Maryland 20817

29d. Date signed (Month, Day, Year)

September 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan		artment rtificate			ind M	lental Hyg	giene Reg. No 20	08	31	131
	Physic /Medi		Decedent's Name (First, Midd ANNA BFILLE								2. Date of Dea Month	ath Bay	Year	3. Tim	e of Death
	Exami		4a. Facility Name (If not institution	n, give street and numb	er)		4b. City,	Town, or	Location o	f Death	~ /-	4c. Count	y of Death		DW
			JEWISH CONVA		JRSING				TIMOR				TIMOR	E	
	Funeral Director		5. Social Security Number 220-03-0628	6. Sex 7. 1 ☐ M 21∑1 F	Age (In yrs.	last birthday) 1 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day 06/05/	h / Year) /1017	9. Birthr	ntry)	te or Foreign
			Usual Residence of Decedent	71							_06/03/	1917			PA
	nyland how		10a. State 10b. County			y, Town or Lo									e City Limits
	Ba-f s	cto	MD	N/A		BALTIM	ORE							1 X□'	Yes 2 No
	with th	Dire	10e. Street and Number	T DOAD			10f. Zip		01 01 5			10g. Citizen of		1	
	ns 234	eral	4150 FALLSTAE	12. Was Decede	ent Ever in II	S 13 1	Was Deced		21215		acify Yes or No-	14 Ra	USA ce - Americ		2
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23a or 28a-f show or other treumatic event, the Medical Evan	by Funeral Director	1 Never Married 2 Mar	ried 1 Yes 2	es?		f Yes, spec		Specify:	Puerto	acify Yes or No- Rican, etc.)	Bla Speci	ick, White,		,
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	Hygien Hygien Sther ti	S	12 17. Father's Name (First, Middle,	(ast)		SEC	RETAR	Y	19 Mothor	r's Name	(First, Middle,	Maidan Suma			
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, Mar	l and 2 sh fealth and m 27 Is m		19a. Informant's Name/Relations ALAN HILLMAN	1		19b. Mailir 5 7 52	-				NEW MARE				
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 any Injury or other to pnce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta	20b. P	lace of Dispo	sition (Nam	e of her place	9)	τ	Date	20c. Location	- City or To	own, State	9
Ë	Part Ar		`4 □Donation 5 □ Other (5	Specify)	HEB	REW OR	SOCT.	ETY			9/2008	BALTIM	ORE,	MD	
Bal	permit. Pa Departmen Importent: any Injury	١.,	21. Signatur of Funeral Service	Licenses		22 Q	. Name and 900 R	Addres	s of Facility	SOI	LEVINS				
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	Physician /Medical		23a. Part1. Enter the disease of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. au	as a consequ	MY	ces.	de	e,	f.	ageno		<	Interval	Between and Death bus
	Examiner		Sequentially list conditions.	b. Co	Sino	12	ari	len	1. 0	lis	ease			76	month
\	ed sit	ine	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):	1	0							- //
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ital		Be C	25. Was case referred to medica examiner?	ı					26. Place	of Death	1 ☐ Yes (Check only or		1 1 1 1 1 1 1 1 1 1	2010	
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	ling P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	19	njury Day Year)	28b. Time of Injury		c. Injury Work			28d. Describe h	ow injury occur	red		
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Div	- 9	Certification;	4 Homicide determ	building,	etc. (Specify	()	ser, ractory,	OIIICO			City or Tow		Joi Oi Tigre	1 110010 1	vumber,
	in in in in in in in in in in in in in i	edical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basis and manner	s of examinat	wledge, death tion and/or inv	occurred a restigation, i	t the time	e, date and inion, death	place, a	and due to the c ed at the time, d	ause(s) and m late and place,	anner as s and due to	ated.	se(s)
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	2		30. Name and address of arson	who completed cause of	of death (Item	23a) (Type, I		1. 1	012	.7	bred	10 mo	0110		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signal	ture 4	24	NX	3/	140	med			- '	
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		for State Registrar	Otate of Me		•	tificate of L		vicitai riyg	eg. No. 2	800	31132
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/Medic	cal	Richard A. 4a. Facility Name (If not institution, give	Denner street and number)			4b. City, Town, or	Location of Death	Septembe		2008 ty of Death	10:32 a ^M
Examin	ier	16 Edmondson Ridg	,			Catons			Ва	1timo:	re
Funeral Director				e (In yrs. last birti	hday) /rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAY 25	1939	9. Birthp Cour Mary	
pur 🖈		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation				1	0d. Inside City Limits
/laryla	ō	MD Baltimo	nre	Caton							1 □Yes 2 🖾 No
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h with	al D	16 Edmondson Ridge	Road			212	228		U	JSA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Evanding mast by retified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🖾 N If Yes, Give Year or Dates:			as Decedent of Hi Yes, specify Cuba □Yes 2X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Ra Bla Speci	ace - Americack, White, o	etc.
2 hour	ted t	15. Decedent's Edu	ıcation	16 <i>a</i> .	Decede	ent's Usual Occupa	ation		16b. Kind of E		
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should nd Me mark	2	19a. Informant's Name/Relationship (7)	/pe. Print)	19b.	Mailing	Address (Street a	and Number or Ru	ıral Route Numbe	r, City or Towi	n, State, Zip	Code)
and 2 salth a 27 is er tra		Heidi D. Tracey -	daughter	580	08 I	Edmondsor	Avenue,	Catons	ville,	MD 2	1228
es 1 and He		20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 ☐ F	Removal from State			ition (Name of atory or other place			20c. Location	- City or To	wn, State
t. Pag tment tant:		4 Donation 5 ☐ Other (Specify))	Metro		natory, I	<u>`</u>		Baltin		MD
permi Depar Impor any ir		21. Signature of Funeral Serving Licens	# H Will	iams	22(Name and Address Pemailion 299 Frede	i Society erick Roa	y of Mary ad, Balti	land, more,	Inc. MD 2	1228
Physician		23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each lin	ie.		r the mode of dyin					Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		a consequence o			7				
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as	a consequence o	of):						
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To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death		Ectopic pregnancy Other (specify)	/			ate of deliventh	ery Day Year
w requires that the d s been signed by the should be detached	y Ph	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in	the un	derlying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to t	he cause of death?
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To t with	Σ	29b. Signature and title of certifier	e W 1	40		D 16			99d. Date sign $9/2$	1	
6		30. Name and address of person who co		eath (Item 23a) (Type, P	rint) TON AV	E BAL	TIMOLE	MD	21	229

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / D		artment of H		nd Mental H	ygiene Reg. No	0000	31133
			Registrar 1. Decedent's Name (First, Middle, Last)	001	imoute of L	Journ	2. Date of D	eath		3. Time of Death
	Physici /Medio		Mildred W. Duckwall				Month Septe	mber	29, Year 200	08 5:05 A.M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of			County of Dea	
7			Carroll Lutheran Village		Westmi				Carroll	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M XXF 7. Age (In yrs. last bin 97		If Under 1 Year Months Days			Day, Year)		thplace (State or Foreign ountry) aryland
	land w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Towr	n or Loc	cation					10d. Inside City Limits
	Mary -f sho	tor	Maryland Carroll Wes	tmi:	nster					1 ☐ Yes 2 X No
	or 28a	Director	10e. Street and Number	CILL	10f. Zip Code			10g. Citi	izen of What C	ountry?
	23a ust b		200 St. Luke Circle		211			of A	merica	
	er de@	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi f Yes, specify Cub <i>a</i>	spanic Origii n, Mexican, i	n? (Specify Yes or N Puerto Rican, etc.)	lo-	 Race - Ame Black, Whi 	
336	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 20 No If Yes, Give Year or Dates:	1	□Yes XXNo	Specify:			Specify: W	hite
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215	ithin 7 ne. nan "r Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done d OO NOT use retired,		or working			
Maryland 21215-0036	filed w Hygier ther the		10th 17. Father's Name (First, Middle, Last)]	Homemaker		s Name (First, Middl		Own Hor	ne
and	d d d d	Be C	Samuel Burton Wright				h K. Norfo		Surname)	
az	s 1 and 2 should be f Health and Mental Item 27 is marked o other traumatic ev	٩		. Mailin	g Address (Street a		or Rural Route Num		or Town, State,	Zip Code)
Ž	and 2 ealth a n 27 Is ier trai		Carol D. Nicoll (Daughter) 10	00 1	Weller Ci	rcle,	Apt. 310	, Wes	tmisnte	er, MD 21158
Baltimore,	0 0 - F		20a Method of Disposition 20b Place of	Dispos	sition (Name of natory or other place alley	- 1	Date		ocation - City or	
Ē	: Pages tment of l tent: If It		Memori.	al (Gardens		2008	Tim	onium,	Maryland
Bai	permit. Pag Department Importent: I eny Injury o		21. ignature of Fuyar II Salvice License	EC.	Name and Addres khardt Fu	s of Facility IneraI	Chapel, I	P.A.		
		-	2 Part Enter the disease, or complications that caused the death. Do n	329 not ente	96 Charmi er the mode of dvind	l Driv	ve, Manche	ester	Mary]	and 21102
	Physician		Inmeriate Cause (Final	4	-12		1	11		Approximate Interval Between Onset and Death
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Š	death certificate be executed e attending physician end id for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3□	Ectopic pregnancy			2	23d. Date of de	livery
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7.	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in	the un	derlying cause give	n in Part I	23e. Did	tobacco u	ise contribute to	o the cause of death?
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cord	law req as beer 2 shou	Completed					24a. Wa	s an		utopsy findings available
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	ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of	1 Yes f Death (Check only	2 No one)	1 ☐ Yes	No No
> >	Physiclan: this certific ral director,	10 1	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient	3 DOA Othe	r: 4 Nursi	ing Home 5 ☐ Res	sidence (6 □Other (Spe	ecify)
	ding P	ion:	The state of the s	ime of njury	28c. Injury Work		28d. Describe	how injur	y occurred	
NISIC NISIC	Attend death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury. At home, far	m. stre		′es 2 □ No		(Street an	d Number or P	ural Route Number,
<u> </u>	al or A s efter I Dire d in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)	111, 0110	ot, idotory, office		City or To	own, State)	urai Houte Number,
	To the Hospital or Attending Physician: within 24 hours elfer death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	, death d/or inv	occurred at the tim estigation, in my op	e, date and pinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner a d place, and du	s stated. e to the cause(s)
	To the To the To the Comple	Me	29b. Signature and title of certifier		29c. License	number		29d. Dat	te signed (Moni	h, Day, Year)
			Bracesto no.		HA	95	5845	- 9	120	SAAD
			30. Name and address of person who completed cause of death (Item 23a) (1	Туре, Р	Print) K	106	S DI	2/10	21/	12008
	4)		LEUN DREWSER, DO.		TA	NE	YTOU	UN	M	1.21787
	Sta Registra		31. Date filed (Month, Day, Year) SEP 3 0 2008	Ana	10° 8					
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DHMH 17 HeV 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 6:00 AM 2008 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 205 CASTLETOWN RD CTIMORE Luthervi Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 219-82-8786 1 □ M 2 🕱 F Yrs. Director 44 Aug. 12, 1964 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Lutherville Maryland Baltimore 1 □Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Modical Experience and the nutritied Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 205 Castletown Road Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 □No Specify Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elevator Mechanic Elevator Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Ann Heck Richard Owen Deeds, Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 Castletown Road, Lutherville, Maryland 21093 Shirley Ann Lam Mother 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or of once. ¥∑NBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 9/29/2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licenses 22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** My ocardial disease or condition /Medical Due to (or as a consequence Examiner 4ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of and The law requires that the death certificate be execu Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. I □Yes signed by the a 2 No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe certificate 1 ☐ Yes 2 🗷 No 2 No Division of Vital 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. investigation 1 □Yes 2 □No 2 Accident the **Director:** 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide within 24 hours at To the Funeral C 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number Baltimire, ND 21218 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 3333 Nost Calvert St. 31. Date filed (Month, 37 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25, \$EPTEMBER 2008 10:40 P M PAUL DUFFY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FOREST HILL HEALTH & REHAB FOREST HILL HARFORD CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Manthe | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months 1 MM 2□ F 80 209-16-2150 Sept. 16, 1928 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No 50ppa Harford Maryland
10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 United States Church Drive 100019 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 No WW 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 工 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaura Chef ecutive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred tarold 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Plint) Susanne Wilson Daughtert 2214 Autumn Glow Ct. BELAIT, MD 21015 SCPE. 27, 20b. Place of Disposition (Name of cemetery, gramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Forest Hill MD 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Beltit
3 New port Dr. Forest Hill, MD 21050 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complica one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mes Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 1☐Live birth 3 ☐ Ectopic pregnancy Day Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes R□ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No

Examiner The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician the as signed by the attending use be detached has page 2 certificate or Attending Physician: this After within 24 hours after death To the Funeral Director: filled in by

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural', or

12 should be filed within 7 h and Mental Hygiene. 7 **Is marked other than "r**

the Medical

t: If item 27 I Pages 1 and 2 ment of Health

Department o Important: If any Injury or once.

Physician

/Medical

Funeral Director

Completed by

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Examiner

Completed by Physician/Medical

Be

Medical Certification: To

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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BEL AIR, MD.

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State Registrar

31. Date filed (Month, Day, Year) SEP 3 0 2008

DAVID DUNN

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 7:25AM Doris Irene Drewen 2008 ent 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗓 F 193-14-9137 85 08/23/23 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Howard Ellicott City 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 3004 North Ridge Road 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Dry Cleaning 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Charles Pendleton Florence Edwards 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Marie DeMarco 8996 Furrow Avenue Ellicott City, MD 21042 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 09/28/ 2008 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Singleton Funeral & Cremation Services 1 2 ND Avenue S.W. Glen Burnie, MD 21061 M00918 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mon 1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Unknown ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 □K10 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of 28d. Describe how injury occurred Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lajury or other traumatic event, the Medical Evanine Internatible at once.

altimore, Maryland 21215-0036

burial-transi been signed by the attending physician and should be detached for use as the burial-tran O. Box 68760. the Records. Vital ð Division Hospital or Attending Director:

Examiner

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	Part II. O
	25. Was exam 1 \(\)
	27. Mann
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Physician/Medical Completed by Certification: 29a, Certifier Medical

25. Was case referred to medical
examiner?
1 ☐ Yes 2√X NO
IL les ZIANO
07 Monney Month

tural 5 Pending investigation ccident 6 ☐ Could not be Suicide determined 4 Homicide

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

20965

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVENUE, BALTIMORE, MD 21229 Boddu 900 5 Neeraja

31. Date filed (Month, Day, State

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

Registrar

			For State	State of	Marylan		artment of rtificate of			1ental Hy	0.1	100	21137
			Registrar 1. Decedent's Name (First, Midd	fle (ast)				Deall		2. Date of De	Reg. No.	100	3. Time of Death
	Physici		Frank		lGavio.	٦r				Month	ber 27,	Year	11:24 a ^M
1	/Medid Examir		4a. Facility Name (If not institution			, 51.	4b. City, Town,	or Location	of Death	ach rem		nty of Death	_ 11:24 a
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	Funeral		5. Social Security Number		. Age (In yrs. I	last birthday)	If Under 1 Year	If Unde	r 24 Hrs.	8. Date of Bi	rth	9. Birth	place (State or Foreign
	Director		218-44-2767	1 √ M 2□ F	64	Yrs.	Months Days	Hours	Min.	April	3,1944	Mary	Tand
	put 💉		Usual Residence of Decedent 10a. State 10b. Count		100 City	y, Town or Lo	eation						Od Ipoldo City Limite
	sho	ō.			Too. City								10d. Inside City Limits 1 ☐ Yes 21 No
	the M	ect	Maryland Bai	ltimore		Towso	10f. Zip Code				10g. Citizen o	t What Cour	
	with	Ö	5 Goucher W	and Court				286			USA	ii what Cou	nti y :
	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show its Modical Extriting must be notified at	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.S	S. 13.	Was Decedent of If Yes, specify Cu		rigin? (Sp	ecify Yes or No		ace - Ameri	can Indian.
9	or itel	Ē	1 ☐ Never Married 2 Ma	Armed Forc	Y No					Rican, etc.)	В	lack, White,	etc.
93	ral", c	d by	3 ☐ Widowed 4 ☐ Divorce	I IT YES GIVE	es:		1⊡Yes 2√∑No	Specify	<i>/</i> :		Spec	^{eify:} Whi	te
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21215-0036	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Sal	DO NOT use retir	ed)			 Gravbar	Fler	tric Co.
	filed v Hygie other i		17. Father's Name (First, Middle			001		18 Moth	er's Name		, Maiden Surn		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Mexical Exercitor must be notified at once.	To Be	Frank V.	DelGavio,	Sr.				Edith		Bus		
ary	2 should had his man	Г	19a. Informant's Name/Relation			1	ng Address (Stree			al Route Numb	oer, City or Tow	n, State, Zij	Code)
	1 and 2 Health em 27 i		Cheryl A. DelGa	avio / Wife		5 Gou	cher Woo	d Cou	rt 1	owson,	Maryla	and 21	286
altimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1	3 ☐ Bernoval from St	1 00	lace of Dispo emetery, crei	sition (Name of natory or other pla	ace)		Date	20c. Location	n - City or To	own, State
ţi	t. Pac tmen tant: ijury		4 Donation 5 Dother (Specify)			Valley C		10/3/	08	Timoniu	•	
Bal	permit. Pag Department Important: I any injury o once.		21. Signature of Fulleral Service	Rec		ı	2. Name and Addr UCK TOWS		*	. Home,			rk Road Md.21204
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1	/Medical		resulting in death)		as a consequ	uence of):							
	Examiner	<u>.</u>	Sequentially list conditions,	b									
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Вох	eath certifi attending por use as	M/ne	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnai		Ectopic pregnar	101			23d. [Date of deliv	ery
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			25. Was case referred to medica	al l				26 Place	a of Dooth	1 ☐ Yes	2 No	1 □Yes	2 □No
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Division of	or Att	Certification:	3 Suicide 6 Could 4 Homicide deterr	Linear 1 26e, Place of	f Injury - At hor , etc. <i>(Specify</i>	me, farm, str	eet, factory, office			28f. Location (City or To		nber or Run	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 X Certifyi	ng Physician: To the b	est of my know	wledge deat	occurred at the	time date a	and place	and due to the	cause/s) and	manner as	stated
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	15		30. Name and address of person	who completed cause	of death (Item	28a) (Type,	Print)				1	('	
	1		DR. ERNESTINE				ALLEY RE	TI	MONI	JM, MD	21093		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0.0

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cal	4a. Facilit	v Name (I	f not institution	give street and num		IEW	4h City	Town, or	Location of	Death			9, 2008 County of	Death	9:05
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) r 25 2008 **Physician** September 2:41pmM HEDY L. EDWARDS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MARYLAND GENERAL HOSPITAL-ER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 68 Director 220-36-8557 MARYLAND June 21 1940 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is anarked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2319 McCULLOH STREET 21217 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2XXMarried 1 ☐ Yes 2**XX**No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR KEYSTONE PHARMACY 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PROCTOR TAYLOR ELLA L PAYNE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter L. Edwards/Husband 2319 McCulloh St., Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Wall 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 10/03/08 BALTIMORE, MARYLAND 21. Signature of Funeral Service Liouvee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or 68760, attending physician Physician/Medical as the l Box for use IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 0 After this certificate has been signed by the a funeral director, page 2 should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \sum No Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 1 Inpatient 2XER/Outpatient 3 □ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

completely

Medical

29a. Certifier

29b. Sign

one)

(Month, Day,

SEP 3 0 2008

Medical Examiner

and manner stated.

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

1 Certifying Physiciam: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Flaks September 29 2008 1:50 Alberto Jaime /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3520 Courtleigh Drive Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG 29 1933 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Sex 1 ☐ M 2 ☐ F **Funeral** Months Days 75 059-38-2678 Director Argentina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, "to Medical Examination ust be notified at Director 1 ☐ Yes 2 X No MD Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3520 Courtleight Drive 21244 USA Funeral iled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Specify: White <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Israel Flaks Sara Juritz ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Olga Flaks - wife 3520 Courtleigh Drive, Windsor Mill, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/29/2008 4 □ Donation _____ 21. Signature of Funeral Service Licensee Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCEEATI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and line in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe Yes 2 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1∐ Yes 2 Wo Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 Pending investigation death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES ST. N. 69 65 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #30 per DVR g883 9/30/08 CETtificate of Death

Registrar

Registrar Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 27, Year 2008 6:07 PM Joann V. Field 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Joseph's Medical Center Baltimore Towson 8. Date of Birth (Month, Day, Ye Mar. 18, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 3. 1941 Maryland Hours Min 1 M 2000 Months Days 67 218-38-4642 Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10h County 1√2 Yes 2 □ No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 E. Gittings Avenue 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Husband's Law Firm Paralegal 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph V. Chester Catherine Tarsi 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel S. Field, III Husband 10 E. Gittings Avenue, Baltimore, Maryland 21212 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 9/30/2008 Glen Burnie, Maryland 4 ☐ Donation

☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21. Signature of Fundinal Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Le myo cardial S moul Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 DAHO Month Day Year 5 ☐ Other (specify) 9 I Unknown . Other significant conditions contributing to death_but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No. 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1∐ Yes 2**√** No Hospital: 1 | Inpatient 2 KER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

I or Attending Physician: The law requires that the death certificate be executed after death. burial-trans Division of Vital Records, P.O. Box 68760, physician s the burial attending p certificate has been signed by the rector, page 2 should be detached funeral director, After this s after death.

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23.

Int: If yo other traumatic event, it. "A call E. Aminer must

permit. Pages 1
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Physician

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Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

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Examiner Physician/Medical Completed by Be Certification: To

4 Homicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day Year) 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10755 FA11s Rd Ste 200 Lutherville, MD 21093 SUsan MAry Molinaro,

State Registrar

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To the Funeral C

completely filled Hospital

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31. Date filed (Month, Day, Year) SEP 3 0 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 26, 2008 Рм September 10:10 Ruth Frye /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Overlea Health & Rehabilitation Center Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 89 Buffalo, NY Director 066-12-4204 01/08/1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Baltimore Baltimore Director 1 ☐ Yes 2 X No MD the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 2922 Andrea Avenue 21234 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No ۵ Specify. Specify: White If Yes, Give Year or Dates Maryland 21215-003 3 XWidowed 4 □ Divorced Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", amplying or other traumatic event, If we Medical Exposes. Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) At Home College (1-4or 5+) Hamemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK Alfred Pache **E**mma ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Frye/Son 2922 Andrea Avenue Baltimore, Maryland 21234 altimore, 20b. Place of Disposition (Name of cemetary, crematory of other place)

Evan's Funeral Chapel & Cremation Serv. Bel Air Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 0 9/29 /08 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Charge & Chemation Services 8800 Harford Road Baltimore, Maryland 21234 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one c Approximate Interval Between Onset and Death witer the mode of dying, such as cardiac or respiratory arrest diate Cause (Final Imm diate Cause (I disease or condition resulting in death) a Physician /Medical o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed burial-transit Exami and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 X Yes page 2 should Completed been . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe The certificate 2 □ No 1 □Yes 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X1No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of leath 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? Certification: Hospital or Attending Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical /2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paven Blud

State Registrar 82 Registrar's Sign

DHMH 17 Rev 1/2001

State Registrar Name and address of person who completed cause of death

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m 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SEPTEMBE **Physician** ELDSTEIN /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner HOSPITAL RANDA/GTOWN BALTIMORE NON THENEST COVEN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08/26/1915 9. Birthplace (State or Foreign 3irthplace Country) MD **Funeral** 1 X M 2 □ F Months Days Hours Min 93 215-03-1070 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Martical Examiner mass than a sonce. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3800 OLD COURT ROAD, ROOM 213 21208 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 XYes 2 □ No WWII

If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: WHITE <u></u> 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 PRINTER PRINTING Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J0SEPH FELDSTEIN ပ TDA ROSENBLATT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON FELDSTEIN / DAUGHTER 11 NORTH AVENUE, PROVIDENCE, ŘΙ 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 09/29/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mask 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUMOI disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) /Medical IF FEMALE: 23c If was outcome of prognar

the Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760. attending physician signed by t I be detach After t 24 hours a

Baltimore, Maryland 21215-0036

nysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of delivery Month Day Year		
ted by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRENIC CBSTRUCTIVE PULLENAMY DISTANCE;				. 23e. Did tobacc	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
Comple	Respiratory Fabluse				24a. Was an autopsy performed 1 □ Yes 2 2		
e N	25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
0	1 Yes 2 No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
ation:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐	28d. Describe how in	njury occurred	
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street City or Town, St	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Ca	29a. Certifier (Check only dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						

29c. License number

29d. Date signed (Month, Day, Year)

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State Registrar one)

31. Date filed (Month, SFP 3

29b. Signature and title of certifier

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and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 10:50 A^M Cecilia Estelle Frederick Sep 17, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** Catonsville Manor Care-Woodbridge Valley If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 200 F Months Days Yrs Director MD 84 213.20.7980 May 31, 1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event. It Medical Eneminar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 PNo Director **Ellicott City** MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 21043 5140 Bonnie Branch Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 homemaker at home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Mary E. Kramer Arthur H. Gordon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5140 Bonnie Branch Road Ellicott City, MD 21043 Albert S. Frederick 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sep 20, 2008 Meadowridge Memorial Park, 1/22. Name and Address of Facility Elkridge, Maryland Sign ture of Funeral Service Licentee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final CARUNDIO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ned by the I □Yes 2 □ No Ö 9 Unknown 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by CARDIOVASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 ☐ Yes 2 ☑No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. nours after death. neral Director: / 2 ☐ Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 24

State Registrar

SEP 3 0 2008

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CENTER

29c. License number

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29d. Date signed (Month, Day, Year)

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	Funeral Director		218-42-1364	Sex 1□M 2☐F 66		ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D SEPT.	orth (Pear) 9. 1942 MA	Birthplace (State or Foreign Country) RYLAND
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	h the	Director	10e. Street and Number	·			10f. Zip Code			10g. Citizen of What	Country?
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980	I within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f show fre Medical Eventral must be routified at	by Funeral	11. Marital Status The New er Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 □Yes 2 ▼ If Yes, Give Year or Dates:			Was Decedent of If Yes, specify Cu 1 □Yes 2 1 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	o- 14. Race - A Black, W Specify:	merican Indian, hite, etc. WHITE
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121	filed within Hygiene. ther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	HOMEM.	DO NOT use retir	ed)		OWN HOM	E
Baltimore, Maryland 21215-0036	al Hyg I othe	To Be Co	17. Father's Name (First, Middle, Last JAMES MORGAN TAYL	•				18. Mother's Nar	•	e, Maiden Surname)	
, Mary	es 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		19a. Informant's Name/Relationship ROBERT R. GRUNDMA	, , ,	SBANI	1				ber, City or Town, Stat BURNIE, MD	
imore	permit. Pages 1: Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Dination 5 ☐ Other (Special Contents)		C	emetery, cier EN HAV	sition (Name of matory or other pi EN MEM •	PARK 20	08	20c. Location - City GLEN BURN	
Balt	permit Depart Import any inj		21. Signature of Time I Service Lice	nsee		K K 4	R. Name and Add IRKLEY – R 21 CRAIN	ress of Facility UDDICK FU HWY., S.	NERAL H E., GLE	OME, P.A. N BURNIE,	MD 21061
14.	Physician /Medical	800	23a. Part 1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	ne. L	C G	er the mode of d	ving, such as cardiae	or respiratory	arrest,	Approximate Interval Between Onset and Death
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	e Hospita 24 hours e Funera eletely fille	Medical C	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	hysician: To the best miner: On the basis of and manner sta	f examinat	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to th urred at the time	e cause(s) and manne e, date and place, and	r as stated. due to the cause(s)
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	n		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print)	A	100	Dia	MV
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			Decedent's Name (First,	Middle, Las	t)					2. Date of De	ath	Your	3. Time of E	Death
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	Examin	er	4a. Facility Name (If not inst 13029 JERO		,			•	r Location of Deat VALLEY	h		ounty of Death	E	
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	or 28	Director	10e. Street and Number					10f. Zip Code			10g. Citize	en of What Coun	try?	
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0036	be filed within 72 hours after death with the Maryland that Hygliene. do other than "natural", or items 23a or 28a-f show event, if of Maryland Examinar metals by in affiled at	þ	11. Marital Status 1 □ Never Married 2 🛣 3 □ Widowed 4 □ Divi		Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:			Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)		Black, White, e		
ה	- 4 69	letec	15. Dec (Specify only)	edent's Edu highest grad	ucation de co <i>mpleted)</i>		(Give	lent's Usual Occup kind of work done	during most of wor	rking		of Business/Inc	-	
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yıa	should be filed withir and Mental Hygiene. marked other than umatic event, It e IV.	2	FRANK				BERG		ANNE			ROSEN		
<u>z</u>	ar is		19a. Informant's Name/Rela ERIKA GOLDB		ype. Print) WIFE			•	and Number or Ri				21030	
Je,	es 1 and 2 of Health f Item 27 or other tr		20a. Method of Disposition			20b. Pla		sition (Name of natory or other place		Date		ation - City or To		
Dallimo	Pages treent of tant: If Its lant: If Its jury or o		1 ☐ Burial 2 🛱 Crema #☐ Bonation 5 ☐ Oth	er (Specify	_	CARRO			INC.09/2	5/2008	HAMP	PSTEAD,	MD	
ם	permit. Pages 1 and 1 Department of Health Important: If Item 27 any Injury or other tr once.		21. Signature of Funeral S	Mc	lam			Name and Address Name Address	STERSTOWN	OL LEVII ROAD =	NSON PIKE	& BROS.	, INC. MD 212	208
		945 E	23a. Part 1. Enter the disea shock, or heart failure	se, or comp	lications that cau ne cause on e c lin	the death. e.	Do not ente	er the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Betw Onset and Do	/een
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a. Dua to (or ea.	polen	-	hepatoma					4 years	
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	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Į	Due to (or as a	conseque	ence of):							
	xecute and al-trans	Examiner	that initiated events resulting in death) Last		c Due to (or as a	conseque	ence of):					- 1		
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ממ	eath cert attending for use a	sician/M	23b. Was decedent pregnar in the past 12 months?	IL I	23c. If yes, outcome of	2 🗌 Fetal (death 3 □	Ectopic pregnance	у		23	d. Date of delive	*	ear
5	the de	Physic	1 □Yes 2 □No 9 □ Unknown		4 ☐ Pregnant at 9 ☐ Unknown	time of de	ath 5∟	Other (specify)						
r D	w requires that the described by the should be detached	by Pt	Part II. Other significant co	nditions co	ntributing to death bu	t not result	ting in the un	derlying cause giv	en in Part I.	23e. Did t	obacco use	e contribute to th	e cause of de	ath?
old,	requir								-	1 🗆 `	Yes 2	No 3 ☐ Prob	ably 4 ☐ Ui	nknown
מים וב	Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed								24a. Was autor perfo 1 □ Yes		24b. Were autop prior to con death? 1 ☐ Yes	npletion of ca	
-	/siciar s certif	o Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No	1	Hospital:	ot 2□E	R/Outpatien	Oth	26. Place of Dea er: 4 ☐ Nursing F	ath (Check only o	-	Other (Consider	.1	
5	ng Phy ter thi	on: To	27. Manner of Death	a mallin a	28a. Date of Injur (Month, Day	y 2	28b. Time of Injury	28c. Inju	y at	28d. Describe			<u> </u>	
5	tendir eath. for: Ai the fu	catic	2 ☐ Accident in	ending vestigation ould not be				M 1 🗆	Yes 2 □No					
5	I or At after o Direct I in by	Certification:		etermined	28e. Place of Inju building, etc	ry - At hom . <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (; City or Tox	Street and i vn, State)	Number or Rura	l Route Numb	·er,
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier 1 Cer (Check only one) 2 Med	tifying Phy dical Exami	rsician: To the best of iner: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred at the ti restigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as solace, and due to	tated. the cause(s)	-
	То th within To th сопр	Me	29b. Signature and title of co					29c. Licens		-		signed (Month, i	Day, Year)	
			d .c	horto	Bay, HD			DSC	604		9/24	1/08		
	18		30. Name and address of pe		Sunce 450, 107				21023					
	Stat	te	31. Date filed (Month, Day,	Year)	32. Registra	r's Signatu	ire	-						
	Registra	ar	SEP30	2008	File States 1	F. A	Marke	7						

	1 – 1	For State Registrar			State of	f Mai	ryland	-	artment of F rtificate of I		and M	lental Hy	gien Reg. N	$2 \mathrm{n}$	8 0	3111	+8
Dhysisian	1. De	ecedent's Nan	ne (First, Mid	idle, Last)								2. Date of De	eath Da	av	Year	3. Time of Deat	h
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Examiner			(If not institut errac		reet and nun	nber)			4b. City, Town, or Arnolo		of Death			c. County		ada1	
Funeral		cial Security		6 Say	v	7. Age	(In yrs. la	st birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	rth				eign
Director		58-10-7		1 🗆	M 2 F		95	Yrs.	Months Days	Hours	Min.	AUG 17	, 19	(3	New	place (State or For htry) Jersey	
land ow	-	al Residence o State	of Decedent 10b. Coun	ity		- · · · ·	10c. City,	Town or Lo	cation		-				1	0d. Inside City Lin	nits
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or item		Marital Status ☐ Never Mar	rried 2 Ma		Armed For 1 ☐ Yes	rces? 2 XNc))		Was Decedent of H			Rican, etc.)		Blac	k, White,	etc.	
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permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medionce. To Be Complet	21.	Signature of F	Funeral Service	ce Licensee	с. т	odd.	Dri	ng Cr	Name and Address remation 9 Freder	ss of Facili Socie ick R	ty o	f Maryl	land	, Ind	2.28		
	23a	. Part 1. Enter shock, or he	the disease, eart failure. Li	r complication	ations that ca cause on ea	aused thach lime	he death.	Do not ent	er the mode of dyir	ng, such as	cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death	1
Physician /Medical	dise	nediate Cause ase or conditi ulting in death	ion	a.		C	. A	CF	1 E X	1	A_					Oriset and Dead	
Examiner				1	Due to (or as a	conseque	ence of):	MEN	TI	A						
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To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir		EMALE: Was decede in the past 1: 1 Yes 2 9 Unknow	2 months?	23	c. If yes, outo 1 Live b 4 Pregr 9 Unkno	oirth 2 nant at t	Fetal o	death 3	☐ Ectopic pregnand ☐ Other (specify) _	Э у				23d. Dat Mo	te of deliv	ery Day Year	
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ttendi death. ttor: A the fu	2	Accident	inves 6 ☐ Coul	stigation ld not be	280 Bloom	of Injur	v. At hom	an form str	M 1 □ eet, factory, office	Yes 2		29f Location	/Ctm at a	and Alumb	or or Bur	al Route Number,	
tal or Attending Phys rs after death. al Director: After this led in by the funeral dir Certification: To	4	Homicide	dete	rmined	buildir	ng, etc.	(Specify)	le, iaiii, su	eet, factory, office			City or To	wn, Sta	te)	er or nur	ar noute Number,	
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu Medical Certificatic	29a	Certifier (Check only one)				asis of e	examination		h occurred at the ti vestigation, in my o								
vithir vithir comp	29b.	Signature and	d tigle of certif	fier	w	M	h		29c. Licens	se number	63	145	29d. D	ate signed	d (Month,	Day, Year)	8
4	30.	lame and add	dress of perso	on who com	pleted cause	e of dea	ath (Item 2	23a) (Type,	Pript	TAL	א מ'	2100	=	41	N-	T41C	UA
State	_		nth, Day, Yea	ar)	32. Re		's Signatu		P. 10.	, ,	1 64						
Registrar			JEF (3 0 20	308	Ross	Alas a	A.S. A.	TOBALL.						_		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Day Year **Physician** PM 2113 William H. Hines, Sr. 2008 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Center Franklin Square Hospital Rosedale Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/24/1931 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Min. 1**X**M 2□ F Months Days Hours 76 215-28-1745 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h. County 1∩a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mc Jich Exarciant court or confilmed at 1 ☐ Yes 2 X No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Willow Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Maryland 21215-0036 Specify: If Yes, Give Korean Year or Dates: þ Specify: White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Uniform Rental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James O. Hines Ida Quinn ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. William H. Hines, Jr. - Son 7825 East Collingham Dr. Apt.B Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory of other place)
Saint Stanislaus
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/01/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Puneral Homes P.A. عزو 401 S. Chester Street Baltimore, Maryland 21231 23a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kight Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of) physician at the burial-P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 🗆 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen Yn eumonia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate 1 ☐ Yes 2 🔼 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

541

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

9000 Franklin 32. Restrar's Signature

Biddigi

Registrar

DHMH 17 Rev 1/2001

29c. License number

D0063974

Balto MD

29d. Date signed (Month, Day, Year)

September 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 1, perPHSYS., G883, 9/30/08, WS

State of Maryland/ Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last Marzouk Labib Bebawy Hanna 2. Date of Death 3. Time of Death Day Month 2488 M **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MED Baltimore City CNTR 8. Date of Birth (Month, Day, Year) Oct. 28,1950 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 57 Egypt Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinas must be notified at any injury or other traumatic event, the Medical Eventinas must be notified at any injury or other traumatic event, the Medical Eventinas must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 □Yes 2 X No Director Maryland Prince Georges College Park 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20740 9104 Bridgewater St. Egypt Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🖾 No Specify. Specify: Egyptian q 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Helper Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Labib Bibawy Hanna Mariam Bibawy Khalil ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) R. Sami Zakhari / Friend 8340 Woodward St., Savage, Maryland 20763 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 2008 St. George Cemetery Alexandria, Egypt 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy.,S.E., Glen Burnie,MD uneral Se 3 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YONTANEOUS BACTERTAL PERITONITIS DAY Physician /Medical Due to (or as a consequence of): Examiner OWKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown this certificate has been s al director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Suppatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

DRIENNE

31. Date filed (Month, Day, Year)

SEP 3 0

GLEENE

BACTEMORE.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32. Registrar's Signature

		For State		S	tate o	f Mar	yland		rtmen				1ental Hy	/gien Reg. N	/ 111	8 (31	151
Physicia	_	Registrar 1. Decedent's Name	(First, Middle	e, Last)									2. Date of D Month	eath	ay	Year		of Death
/Medica	al		Leonar						4h City	Town, or	Legation	of Dooth	SEPTEN		27 J	DOS		16PM
Examine	er	4a. Facility Name (If Unic	not institution on Memo						4b. City,		timo			7	N/			
Funeral		5. Social Security Nu		6. Sex	Ī			t birthday)	If Under		If Under Hours		8. Date of B (Month, D	irth Day, Yea		9. Birth	place (State	e or Foreign
Director		216-32-39 Usual Residence of D		1 (2) M	2□ F	70)	Yrs.	Wienario	Dayo			May 1	5 , 1			land	
land ow			10b. County			1	0c. City, 7	Town or Lo	cation								10d. Inside	City Limits
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and 2 lealth a m 27 is ner tra		Linda	E. Har	re .	Wife	<u> </u>		12	36 D∈	ellwo	xod A	venu	e, Balt					21211
Pages 1 ament of He ant: If iten ury or oth		20a. Method of Dispo 1 → Burial 2 □ 4 □ Donation }	Cremation		oval from	State	cem	e of Dispo etery, cren View	natory or o Memo	rial	. !	10/2	Date /2008	Eld	Location - C lersbu	rg,	Maryl	
permit. Depart Import any Inj once.		21. Signature of Fun	eral Service	Licensee	X /.)	22	Name an Burge	d Addres e-He	s of Facili	Seit:	z Funei	cal	Home,	Inc	. 212	211
Physician		23a. Part 1. E. V r the shock, earl Immediate Cause (F	t failure. List ⁻ inal	only one c	ause on e	each line.		Do not ent	3631 er the mod	Fall e of dying	s ko	ad, I	Baltimo	ore,	Mary.	land	Approxim Interval B Onset an	nate Between nd Death
, /Medical Examiner		disease or condition resulting in death)		f a	Due to	(or as a c	onsequer	L FA	ILLK	<u>E</u>							1 WEE	
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cate be executed	Examiner	Sequentially list condificant, leading to immoduse. Enter Underl Cause (Disease or in that initiated events	ying njury	c		LONA		ART	ERY	DIS	BEAS	E					23 YE	ARI
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		1 Live	birth 2 (nant at tir	pregnanc □ Fetal de me of dea	eath 3] Ectopic p] Other <i>(sp</i>						23d. Date Mon		very Day	Year
s that	by Ph	Part II. Other signific	cant condition	ons contrib	uting to d	eath but r	not resultir	ng in the ur	nderlying c	ause give	n in Part	1.	23e. Did	tobacc	o use contri	bute to	the cause c	of death?
w requires t s been signe should be													1 [] Yes	2 🗆 No	3 Pro	bably 42	Unknown
The law rate has be page 2 shu	Completed												24a. Wa auto per 1 ∐Yes	opsy formed	pr de	/ere autrior to co eath? □Yes	opsy finding ompletion o	gs available of cause of
ding Physician: The h. After this certificate h funeral director, page	Be	25. Was case referre		Hosp	nital:					Otho		e of Deat	h (Check only	one)				_
Phys r this ral dir	<u>၉</u>	1 ☐ Yes 2 1 1 1 27. Manner of Death	10		28a. Date	Inpatient of Injury		NOutpatier Bb. Time of			4 LI N		ome 5 Res			<u> </u>	ify)	
tending death. tor: After the fune	Certification: To	1 Natural 2 Accident 3 Suicide	5 ☐ Pendin investig	g gation	(Mon	nth, Day, Y	(ear)	Injury e, farm, str	М		? ⁄es 2 ⊑		28f. Location					
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide	determ		buildi	ing, etc.	(Specify)						City or To	own, Sta	ate) 			umber,
the Hosp nin 24 ho the Fune upletely f	Medical	(Check only 2 one)	2 Medical	Examiner	On the b		xaminatio		vestigation	, in my op	oinion, de		and due to the	e, date a	and place, a	nd due	to the cause	
vith con	2		asimong	alarm	MD					License		394	G	29d. I	Date signed			
5		30. Name and addre	SASII	MANO	SALF	AM,C	NIOI	VME	MORI	AL	Has	PITA	L, BA	LTA	uore	11	MD	
Stat Registra		31. Date filed (Month	n, Day, Year)	18	32. F	Registrar's	Signatur		,									
HMH 17 Rev 1/20	01			-			27											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 3:30PM Clay 28 Timothy Harding 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesipcike Meliay Centre 5. Social Security Number 6. Sex 7. Age (In yrs. last birthol 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months 1 MM 2□ F Days Hours 65 Director 218-40-4714 NOV. 20, 942 moryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1∩a State 10h County 28a-f show injury or other traumatic event, the Mudical Evan is we must be notified at 1 ☐ Yes 2 No Director Edgewood Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21040 United States 23a Kennard Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 PYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married specify: white 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) John .lerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Wilbur Hardina hristine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) B. Joan Harding 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 9-30-08 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur A Funeral Service Licensee 22. Name and Address of Facility
Evans Fenery Chapel Alternation Services Ē 3 Newport Brive Forest Hill, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1cute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a somequence of): and burial-trar Due to (or as a consequence of): attending physician for use as the buria tarding Cary I methy 111 8004 Division of Vital Records, 9.0. Box 6876 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has was an autopsy performed?
Yes 2 No certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 Ño မ 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 24 hours after death. 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

SEP 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Doris J. Harman 11:55 P 27,2008 September 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Timonium Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday 1 ☐ M 2 🗹 F Days Hours Min. 218-14-0731 84 Oct. 02, 1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐Yes 2 X No Adams County Littlestown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25 Shirley Lane 17340 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify: White 3 Ø Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Longfellow Elizabeth VanSkiver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Patrick Harman 25 Shirley Lane Littlestown, PA. 17340 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem.
Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept.30,08 Timonium,Maryland 4□Donation 5 Nother (Specify) Entombment Name and Address of Facility
accord Alternatives Funeral & Cremation Ctr., P.A.
325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service License 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death Immediate Cause (Final ye ws disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if a m, leading to him clats cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for he a conservience of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Evaminer must by notified at

Director

Funeral

Completed by

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland

11:55

2008

SEPTEMBER

P.0.

Records,

Division of Vital or Attending Physician;

Hospital within 24 hours a

HARMAN

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"natural".

is marked other than "natur aumatic event, inc Medical

permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev

burial-transit the attending pl cate has been signed by page 2 should be detact certificate I ours after death.

leral Director; After this certific filled in by the funeral director,

requires that the death certificate be executed

Examiner Physician/Medical Medical Certification: To Be Completed by

Part II. Other significant conditions	contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?							
			1 □ Yes 2 🛭	No 3 Probably 4 Unknown							
			24a. Was an autopsy performed? 1 □ Yes 2 ☑No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 전 No							
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 █No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio		28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred								
3 Suicide 6 Could not be 4 Homicide determined		et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1DC Certifying P	vsician: To the best of my knowledge, death	occurred at the time, date and place.	and due to the cause(s)	and manner as stated.							

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

12008

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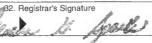
State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

SEP 3 0



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month O **Physician** 2008 4:01 PM narles Hoffman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore University of Maryland Shock Trauma Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 03/22/1929 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 ☐ F Days Hours MARYLAND 263-38-0757 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified *** once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director MD BALTIMORE COCKEYSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13801 YORK RD 21030 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 🗌 No 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 5+College (1-4or 5+) Elementary/Secondary (0-12) SALESMAN PAPER PRODUCTS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES E. HOFFMAN RITA HOFF ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY HOFFMAN (DAUGHTER) 815 WEST 36th ST. BALTO., MD. 21211. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 09/30/08 BALTO CITY, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Shot the Llours bun /Medical Due to (or as a consequence of): CENTRICATION APPROVED IT MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes, CHF, Prostate Ceincer COPD 1 Yes 2 No 3 Probably 4 Unknown Completed Athal Ebrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform Right Breast mass 25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred I Director: After to in by the funera 28c. Injury at Work? Certification: 1 □ Natural 5 Pending investigation 1340 PM 27/2008 1 ☐ Yes 2 ☐ No Gun shot to the head 2 ☐ Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Ryral Route Number, City or Town, State) 1300 \ York Roud Apr F 7 determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in Nursing Home Cockeysville MO 21030 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

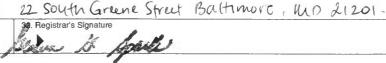
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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) State SEP 3 0 2008 Registrar

Gerard De Castro



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19863

2008

1-	For State Registrar
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State of Maryland / Department of Health and Mental Hygien [] 0 8 Certificate of Death

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Physician
/Medical Examine

			Decedent's Nar	ne (First, Middle, La	st)						2. Date of De		Voss	3. Time of Death
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				re Irving				Baltin					N/A	
	Funeral Director		5. Social Security 220–14–3	3191	ex	Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir Month, Da SEP 23	, 1915	Cou	olace (State or Foreigr ntry) inia
	laryland show		Usual Residence	10b. County		10c. City,	Town or Lo	ocation						10d. Inside City Limits
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	ith the M or 28a-f	irec	10e. Street and No	nwper				10f. Zip Code				10g. Citizen	of What Cou	ntry?
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	tems	Funerai Director	11. Marital Status		12. Was Deceder Armed Forces	s?		Was Decedent of If Yes, specify Cub	Hispanic O oan, Mexica	rigin? (Spean, Puerto F	cify Yes or No Rican, etc.)		Race - Ameri Black, White,	
36	ours after death with the Maryla rel', or Items 23a or 28a-f show Exercises sout Le notified at	by F		ried 2 Married 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	_		1 ☐ Yes 2 🕱 No	Specify	y:		Spe	city: R1.	ack
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218	thin 7 e. an "n	Completed	(Specification)	ondary (0-12)	de completed) College (1-4o	r 5+)	life.	kind of work done DO NOT use retire	during mo ed)	st of workin	1g			
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E O	Pages tent of int: If its iry or o			Cremation 3 ☐ 5 ☐ Other (Specification)		0		matory or other pla ematory,	, I	9/30/	2008	Balti	more,	MD
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m	Depril Impo		15	Huli				Crematic 299 Fred	lerick	Road	or mar l, Balt	yrand, imore,	MD 2	21228
Г			23a. Part1. Enter shock, or he	the disease, or com art failure. List only	one cause on each	line.	Do not ent	er the mode of dyi	ing, such a	s cardiac or	respiratory a	rrest,		Approximate Interval Between
	Pnysician	'n	Immediate Cause disease or conditi	on	a (0	NSE	> TIV	ULMSNA	FAR	1 F	FALL	RE		Onset and Death
4	/Medical Examiner		resulting in death)		Due to (or a	s a conseque	nce of):		0.5	-	0 . i	^^		
		Į.	Sequentially list confrany, leading to it	onditions,	b. (2°C U	CCENT is a conseque	uce op.	UCMJNA	HO	FM/	3001	141		
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Registrar

SEP 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September **Physician** 2008 3:00 AM Kline Eav Oman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Rehabilitation Extended Care Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) February 21,1950 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**⊠**M 2□F Months Days Hours 58 219-52-4492 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or frame only injury or other traumath. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Dundalk Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 7806 New Battle Grove Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 Married 1 □Yes 2 🛚 No White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 years Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy West Donald Kline ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brad Kline Brother 7806 New Battle Grove Road, Dundalk, Md. 21222 Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/30/08 New Church Hill Cemetery Port Royal, PA. 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Liger Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. P. t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Small Cell Immediate Cause (Final disease or condition resulting in death) an cer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): iptial or Attending Physician: The law requires that the death certificate be executed ours after death.

ever a first price for a After this certificate has been signed by the attending physician and filled in by the funeari director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 1 No 1 ☐ Yes 1 Yes 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP30

2008

DHMH 17 Rev 1/2001

Wills # MD.

32. Registrar's Signature

29c. License number 0 4 1 3 6 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Boulevard, Baltimore, Maryland 21218

29d. Date signed (Month, Day, Year)

September 29, 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 6:30 A M September 28, 2008 Knapp Donald. Ε. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll 7200 3rd Avenue, C002 Sykesville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X**M 2□ F Months Oct 29, 1922 Maryland 85 Director 220-05-8706 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Sykesville Carrol1 Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 USA 7200 3rd Avenue, C002 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner once. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eyeglass Proprietor 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Knapp P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21811 3203 Points Reach, Berlin, MD Celeste Bossle/Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 10/1/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 Denation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 21. Signature of Furnera Service License Bryan W. Clary 22 Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Approximate Interval Between Onset and Death 23a. Part1 Enter the i sease, or complications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart filture. List only one cause in each line. Immediate Cause (Final disease of condition resulting in death) Pannewic **Physician** Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death
9□Unknown 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown dispuse Completed univary 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed 1□ Yes 2☑No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ۴ After this 28a. Date of Injury (Month, Day Year) 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 29 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Tan MD 1645 Liberty Road & Iders burg MD 21784 31. Date filed (Month, Day, Year) 32. Registrar's gignature SEP 3 0 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2008 Sept. Physician 26, Kastanaras 2:34 Рм Anna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Feb. 22, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🗷 F 216-68-3988 89 Feb. Greece Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Madical Examiner must be notified at 1 ∏Yes 2 X No Director Baltimore Cockeysville Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1135 Dulaney Gate Circle 21030 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ Specify. 3 Midowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pappazisoglou Zinon Eleni Demetroulis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: If item 27 is any injury or other trau once. Theano Demetrides/Daughter 1135 Dulaney Gate Circle Cockeysville, Md. 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State St. Demetrios Cem. 9/29/08 Cub Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) BLADDER CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) of Vital Records, P.O. Box 68760, the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform certificate 1 □Yes 2XINo Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 🗶 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical

State Registrar

within 2 To the

0

2008

SEPTEMBER 26,

ANNA KASTRANARAS

DHMH 17 Rev 1/2001

29b. Signature

31. Date filed (Month, Day, Year)

title of certifier

SEP 3 0 2008

ERNESTINE WRIGHT

30. Name and address of person who completed cause of death (Item 23a) (T

Print) oe.

VALLEY RD.

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

and manner stated.

2300 DULANEY

82. Registrar's Signature

P.O. Box 68760,	death certificate be executed
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ems cr.m.	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White,	
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2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Evariner must be rotified at		3 LX vvidowed	15. Decedent's E	Year or Dates:	6/28/1946	Decedent's Usual Occupa	ation		16b. K	ind of Business/Ir	ndustry
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of Health Item 27		20a. Method of Dis	position		20b. Place of	Disposition (Name of crematory or other place		Date		ocation - City or T	own, State
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it is a completely filled in by the funeral director.	Medical (29a. Certifier (Check only one)			of examination and	death occurred at the tir d/or investigation, in my o					
Vithin To th COMP	Me	29b. Signature and	title of-certifier			29c. License	e number		29d. Da	ite signed (Month	, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 26 per dr., g883,09 30 (984h) of Death Reg. No. 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Month **Physician** 6.45AM /Medical 4a. Facility Name (If no institution, give styleet and number) 4c. County of Death Nown, or Location of Death Examiner MADE ON KOA4 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 □ Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 382 Funeral filed within 72 hours after death Was Decedent Eve Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status in U.S 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Vidowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Flementary condary (0-12) College (1-4or 5+) 17. Father's Name 18. Mother's Name (First, Middle, Maiden Surname, (First, Middle, Last, Be Pages 1 and 2 should be nent of Health and Mental 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 75 □ Other (Specify) 4 Donation 21. Signature g Funeral Sartice Licen nplications that caused the death. Do not enter the mode of dying, one cause on each line. Approximate Interval Between Onset and Death art failure Immediate C se (Final disease or condition resulting in death) **Physician** 405 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tyes 2 🗌 No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy 1□ Yes 26 No Vital Physician; completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Cousin's Hospital: Other: 4 Nursing Home 5 nesidence 6 Other (Specify) 1 Tes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this ō House 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar 30. Name and address

Date filed (Month, Day,

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who completed cause of d

32. Registrar's

Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Justin Johnson-Lips	State of Maryland / Department of Health and Mental 1- For State Certificate of Death Registrar		2 U U g. No.	8 3116		
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	2. Date of Death Month September	Day Year 26, 2008	3. Time of Death 0416 hrs		
	4a. Facility Name (if not institution, give street and number) Harbor Hospital 4b. City, Town, or Location of De Baltimore	eath	4c. County of Death			
Funeral Director	218-45-1606 1 X M 2 F 12 Yrs. 1	Hrs. 8. Date of Birth Min. 12/11/	n(MM/DD/YYYY) 9. Bir Foreig Co			
d any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 X Yes 2 No		
th the Maryland 23a or 28a-f show notified at once,	10e. Street and Number 10f, Zip Code		g. Citizen of What Cou	ntry?		
er death wi , or items r. must be Funera	401 AUDREY AVENUE 11. Marital Status 1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes Give Year 1 Yes 2 X No specify:	(Specify Yes or No-	USA 14. Race - Ameri White, etc. BLAC	ican Indian, Black,		
5-0036 led within 72 hours aft lygiene, other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT Tor Dates: 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	retired)	16b. Kind of Business/	EEDS		
Baltimore, MD 21215-003 germit Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med	EDWIN LEE EIT SCORD	HI BECKNE	laiden Surname) Lee			
t, MD 21 and 2 should ealth and Me teni 27 is mai traumatic ev	19a. Informant's Name/Relationship (Type, Print) Grandmoth 12b. Mailing Address (Street and Number DOROTHY LIPSCOMB mother 401 AUDREY AVE. BALT	IMORE, MD	21225	117		
more, Pages I and tent of Heal Int: If iten	20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) BAYVIEW CREMATORY 9	Date /30/2008	20c. Location - City or BALTIMORE,			
Baltir permit: b Departme Importa	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Modern Part Part Part Part Part Part Part Part	CCULLY POI	YNIAK FUNE	RAL HOME PA		
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinal failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seizure disorder with complication but to (or as a consequence of):		st, shock, or heart	Approximate Interval Between Onset and Death		
led Insit Examiner	Sequentially list conditions, lf any, leading to immediate couse. Enter Underlying Causs (Disease or injury that initiated					
recui	events resulting in death) Last Due to (or as a consequence of): d. X UNPENDED X AMENDED X AMENDED	T	- 005 11	4 = 400		
). Box 68760, the death certificate be every the attending physician ched for use as the burial Physician/Medic	X UNPENDED X AMENDED #17,18, perf H good 11/12/06 1 X AMENDED #17,18, perf H good 11/12/06 1 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		230. Date of deliver	y Day Year		
cords, P.O. Ba aw requires that the de nas been signed by the 2 should be detached? 1 pleted by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	bacco use contribute to			
Rec The l		24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of es 2 No		
Vital ysician: this certi	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other No.		Residence 6 Othe	r:		
sion of Vital I utending Physician: death. ctor: After this certifi y the funeral director, cation: To Be (27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		ow injury occurred			
Division of Hospital or Attending of thours after death Funeral Director: After redy filled in by the funeral al Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St		ural Route Number, City		
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) Wedlcal Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.					
Me is i	29b. Signature and title of certifier O.C.M.E.		29d. Date signed (Mo			
(3)	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201				
State Registrar	31. Date filed (Month, Day, Year) SEP 3 0 2008 32. egistrar's Signatu					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death SEPTEMBER 28, 2008 **Physician** Daniel Edward Lauterbach, Jr. E:DE AM /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 3 9. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) **Funeral X** M 2□ F Months Days Hours Min. 218-14-6245 Sept. 84 Director Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 ☐Yes 2√2 No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 12251 Roundwood Rd. #309 21093 23a USA Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? Y☐Yes 2☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married A Married Baltimore, Maryland 21215-0036 ō white 1 ☐ Yes 2 TXNo If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Broker Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel E. Lauterbach, Sr. Mary Claire Lee ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health as permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. Thelma Lauterbach/wife 12251 Roundwood Rd. #309, Timonium, MD 21093 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/2/08 Date 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 21093 4 ☐ Donation 5 ☐ Other (Specify) Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Plagle 10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Dav Year 5 ☐ Other (specify) P.0. 1 Yes 2 No detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should LEWY BODY DEMENTIA CHRONIC ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2X No certificate 1 □ Yes 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XX No Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

9+1

State Registrar

29b. Signature and title of eartifier

31. Date filed (Month, Day, Year) SEP 3 0 2008

JEFFREY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1

SWETT

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32. Registrar's Signature

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TOWSON.

MARYLAND

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Beryl A. Lanterman 12:55 AM september 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) California 8. Date of Birth (Month, Day, Year) Months Days Hours Min 564-34-9751 30 M 2 □ F Yrs 78 10/29/1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Hunt Valley 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 400 Symphony Circle 371-B 21030 of America 12. Was Decedent Ever in U.S. Armed Forces? 1ĂŢYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Elementary/Secondary (0-12) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Monette Lanterman Mable Jones Ludlum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 N. Joan Lanterman / wife 400 Symphony Circle 371-B Hunt Valley, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Air 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 24 ☐ Cremation 3 ☐ Removal from State 28, 2008 4 Donation 5 Dother (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee eaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE ARDIOMYOPATH weeks disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Yes 2 No Other: 4 \(\subseteq \text{ Nursing Home} \) 5 Residence Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation

Examiner Examiner law requires that the death certificate be executed use as the burial-trar Box 68760, attending physician Physician/Medical for the detached Division of Vital Records, Completed

P.0.

Physician: The

or Attending

Physician

/Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Department of Health and Mental Hygic Important: If Item 27 is marked other I any injury or other traumatic event, III sonce.

72 hours after

Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

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traumatic event, the Medical Evandrate must be notified

ate has been signed by page 2 should be detach certificate funeral director, this After within 24 hours after death To the Funeral Director: filled in by the

Be

Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

SEP 3

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28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

determined

29d. Date signed (Month, Day, Year,

Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day **Physician** Lomax 2008 Richard William /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Feb. 5, 1926 5. Social Security Number **Funeral** 1 ፟ M 2 □ F Months Days Hours Min. MD 82 214-20-5222 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show Department of Health and Mental Hygiene. Important: If item 2.13a or 28a-f show important: If item 27 is marked other than "natural", or items 2.3a or 28a-f show any injury or other traumatic event, the Medical Evan that he mutthed at once. 1 ☐ Yes 2 X No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 U.S.A. 709 Wimmer Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) J.L.Clark Mfg.Co. Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen L. Boyd Thomas R. Lomax 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Eunice A. Lomax/ Wife 709 Wimmer Road Glen Burnie, MD 21061 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Oct. Date Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Brooklyn Park, MD Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen BUrnie, MD 21061 MOIIZI Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 3/7 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number M 2008 who completed cause of death (item 202a) (Type, Print) 0 21001 32 Registrar's Sig State Registrar

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

SEP 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0024 AM September 2008 Paul Lopata /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORG BALTIMORE CITY **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□ F Director 204-12-8370 Nov 22, 1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2986 Bethany Lane 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ MYes 2 □ No iYes, Give Year or Dates: 2/11 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 2/16/1943 Baltimore, Maryland 21215-0036 1 □ Yes 2 No \$ Specify: White 3 ☐ Widowed 4 ☐ Divorced 2/11/1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetin. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Lopata ဂ Mary Skerchock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Darrow Drive Catonsville, MD 21228 Cynthia Lopata 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sep 29, 2008 Garrison Forest, Maryland Maryland Veterans Cemetery 21. Signature of Funeral S 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 TMULES 23a. Part 1. Substitle dis 74 st., or complications that cause shock, or heart fail in List only one cause on each in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirater **Physician** /Medical Due to (or as a consequence of): Examiner pronau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): The law requires that the death certificate be executed Exami physician and s the burial-trans magestive Due to (or as a consequence of): P,O. Box 68760 Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performs certificate 1 ☐ Yes 2 🔼 No 2 X No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director:

completely filled in by the fi investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANDA

29c. License number

000

29d. Date signed (Month, Day, Year)

September 25, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07305 State of Maryland / Department of Health and Mental Hygiene Christopher George Murray Certificate of Death 1- For State Reg. No 2. Date of Death 3. Time of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day Y September 25, 2008 Physician/ 1237 hrs Medical Examiner Christopher George Murray 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles Waldorf 10470 Cricket Court 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funerai Days Hours Country) Months 1969 PA APR 4, Director 39 209-64-7195 1 **X** M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 X No Waldorf Charles 23a or 28a-f show notified at once. 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Number **USA** 20601 10470 Cricket Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married 2 X No Yes White Yes 2 X No specify. Specify: If Yes, Give Year Divorced Widowed ģ 6b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Construction Project Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Karole Ann Broome Be Jav Patrick Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Ironville Pike Columbia PA 17512 Jay Patrick Murray/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 XCremation 3 Removal from State 9/29/08 Baltimore, MD Metro Crematory, Inc. permit. Pages
Department o
Important: | 21. Signature of Funeral Service Licensee C. Todd Dring

22. Name and Address of Facility

Cremation Society of Maryland. In 299 Frederick Rd Baltimore, MD 21

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Donation 5 Other Specify Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death 'Medical a Intraoral shotgun wound Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Sequentially list collidations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): and Physician/Medical AMENDED UNPENDED ned by the attending physician a detached for use as the burial -23d. Date of delivery The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. icate has been signed by page 2 should be detached Records, P.O. Yes 2 No 3 Probably 4 Unknown δ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy death? performed? No 1 🗸 Yes 2 After this certificate funeral director, page 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other 4 Residence 6 V Other: Scene Hospital: 1 Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot self Certification FOUND: Yes 2 V No Natural Pending after death. the Sep 25, 2008 1237 hrs 28f. Location (Street and Number or Rural Route Number, City 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 10470 Cricket Court, Waldorf, MD within 24 hours after To the Funeral Dire 3 V Suicide Could not be determined (Specify) Single Family Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 26, 2008

OCME 2006

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

2008

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year,

EP3

Assistant Medical Examiner

32 Registrar's Signature

The State of the S

O.C.M.E

111 Penn Street, Baltimore, MD 21201

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SEPTEMBER 28,2008 $5:40_{n}$ BRADLEY W. MCDANIEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HAVEN NURSING HOME CATONSVILLE Under 1 Year | If Under 24 BALTIMORE 8. Date of Birth (Month, Day, Year) NOV 3, 195 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min 52 219-64-1484 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" -- " any injury or other traumatic excess." 10b County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 XNo Director MD Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1421 Madison Park Ave 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unemployed N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James McDaniel Louis M. Bradlev 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Murphy/Brother-in-Law 5009 Blythewood Rd Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 9/30/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring MacNabb Funeral Home, P.A. 301 Frederick Rd Catonsville, Coll 23a. Part1. Enter the disease, or comerications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician irrhosis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the d 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Anknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate has ospital or Attending Physiclan; Ti hours after death, ineral Director: After this certificate y filled in by the funeral director, pa 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Ves 2 → Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h. Time of 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 2 Accident 1 Yes 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DA7683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mille Kunnond Main Street Smile 20, MD 21136 Rustesbur 31. Date filed (Month, Day, Year) 32/Registrar's Signature State Registrar SEP30 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** September 28, 2008 Mooney 8:40 P George /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death Examiner Baltimore Stella Maris Hospice Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Hours | Min. June 25, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 XM 2 □ F 218-26-6326 77 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 XNo Director ms 23a or 28a-f s count be coulfed Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21222 6544 Parnell Avenue LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 7 is marked other than "natural", or item traumatic event, the Medical Examiner. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. If Yes, Give Year or Dates: ð Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Steel years f Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Thomas Mooney Ora Markel ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Eustacia Anne Moonev 6544 Parnell Avenue, Dundalk, Maryland permit. Pages 1 a.
Department of Hea.
Important: If Item 2.
any Injury or injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA Cemetery 20a. Method of Disposition 20c. Location - City or Town, State October 2, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or shock, or heart failure List r complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, t only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 COther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To HOSPICE funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination a and manner stated. d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one within 2

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Registrar

8:40

2008

SEPTEMBER 28,

GEORGE MOONEY

ERNESTINE WRIGHT 31. Date filed (Month, Day, State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

2300 DULANEY VALLEY RD. 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

2008

(Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ronald G. Morgan, Sr. sept 24, Year **Physician** 2008 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 838 West 36th Street Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□ F Yrs. 19, Feb. 1945 Director 220-42-6663 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at Maryland N/A Baltimore 1XXes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 838 W. 36th Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ŽNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 Specify: White 1 □ Yes XX No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Maintenance Person AAI Corp event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 Is marked oth any lipluy or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse L. Morgan, Sr. Mittie Mae Ford ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elnora Morgan Wife 838 W. 36th Street, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gardens of Faith 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/29/2008 Fullerton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21. Signature Juneral Service Licer 21211 our Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as rardic or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a **Physician** disease or condition resulting in death) /Medical Due to r as a consequence of): Examiner Equandary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Il Records, P.O. Box 68760, Ex physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 1 Yes_2No Certification: To 5 Residence 6 □ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation ours after eath.

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filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral i Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. (Check only one) 29b. Signatura License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/200

State

31. Date filed (Month, Day,

Year)

2008

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32. Registrar's Signature

Larry Wayne McCormick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland	/ Department of H	ealth and Me	ntal Hygiene

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, ,		-For State Certificate of Death	Reg. No		
Physicia ' Exami	ın/ ner	Larry Wayne McCormick	2. Date of Death Month Day September 25	Year , 2008	3. Time of Death 1108 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2000 Codd Avenue Dundalk		nty	
Funeral Director		5. Social Security Number 213-38-5384 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM April 19	W/DD/YYYY) 9. Birti Foreigi , 1942 Cou	nplace (State or n ntry) Mary land
Maryland 28a-f show any d at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City 10c. City, Town or Location 10c. City 10c. Cit			10d. Inside City Limits 1 Yes 2 No
i with the Maryland ms 23a or 28a-f shov be notified at once.	Dire	10e. Street and Number 2000 Codd Avenue 10f. Zip Code 21222	Oİ	itizen of What Coun 11 ted Stat America	try? ces
after death with the Maryland al", or items 23a or 28a-f Sh- iner, must be notified at once	Funeral	11. Mantal Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married Forces? Yes 2 No 3 Widowed 4 XXDivorced If Yes, Give Year 1 Yes 2 X No specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	
2 hours afte "natural", I Examiner	۵	3 Widowed 4 XX Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	red)	Kind of Business/I	ndustry
215-0036 be filed within 72 hours at ntal Hygiene. rked other than "natural ent, the Medical Examin	Completed	17.1 dillot 3 radio (1 not, made)	(First, Middle, Maid		/ing
Me Me	To Be	Blaine R. McCormick 19a. Informant's Name/Relationship (Type, Print) Doras Rodney/ sister Laura M 19b. Mailing Address (Street and Number or R 1404 Clark Avenue Lu	Myrtle Sin Rural Route Number, atherville	City or Town, State	, Zip Code) nd 21093
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic	ij	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 XXBurial 2 Cremation 3 Removal from State West Disposition (Name of cemetery, West Disposition (Name of cemetery, West Disposition (Name of cemetery, Church Cemetery)	pate 20 cember , 2008 V	c.Location-City or Vhitehall	Town, State Maryland
Baltin permit. Departm Importa injury o		21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternativ 23.25 York Road Ti	ves Funera Lmonium, N	al &Crema Maryland	tion Ctr.,P.7 21093 Approximate Interval
Physician ∦edical ≟xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):			Between Onset and Death
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Box 6876 e death certificat the attending phy ed for use as the	sician/	1 Yes 2 No 9 Unknown 23b. Whose decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	ancy	Month	Day Year
i, P.O. Be ires that the de signed by the 1 be detached fi	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes	2 No 3 Pro	the cause of death?
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Division of Vital Records, P.O. Box 687 pital or Attending Physician: The law requires that the death certific usins after death. eral Director: After this certificate has been signed by the attending I filled in by the funeral director, page 2 should be detached for use as the control of the death of the control of the death of the control of the death of the control of the death of the control of the death of the control of the death of the control of the death of the control of the death of the control of the death	Certification:	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be 28a. Date of Injury FOUND: 128b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 OND: 10 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 OND: 1100 hrs 28e. Place of Injury 28b. Time of Injury 1100 hrs 28e. Place of Injury 28b. Time of	Subject shot s	eet and Number or F	tural Route Number, City
Hospi 24 hou Funer			d due to the cause(s	nue , Dundalk, ME s) and manner as sta	ated.
To the Hos within 24 h To the Fun completely	Medical	29b. Signature and title of certifier 29b. Signature and title of certifier O.C.M.E. OG	2	29d. Date signed <i>(M</i> September 26,	onth, Day, Year)
141		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore	re, MD 21201		
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

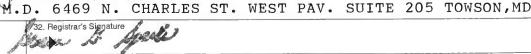
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPT. 2008 **Physician** 8:10p M HENRY W. MATTHEU /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE PARKTON 20600 YORK RD 8. Date of Birth (Month, Day, Year) 10/8/1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. MARYLAND 1 M 2 □ F 78 212-28-6151 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No PARKTON MD BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21120 USA 20600 YORK RD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1-⊠Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: WHITE Baltimore, Maryland 21215-0036 Specify ģ 3 ☐ Widowed 4 ☐ Divorced al Hygiene.
d other than "natura"
event, the Medical E 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CU-TRONICS COMPUTERS COMPUTER CIRCUIT BOARDS 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) MARIE SCHENNING WALTER R. MATTHEU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20600 YORK RD PARKTON, MD. 21120. NANCY R. MATTHEU(WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 10/01/2008 TIMONIUM, MD. DULANEY VALLEY 4 Donation 5 Dother (Specify) Name and Address of Facility 21. Signature of Full al Service Liounsee HENRY 16924 W. JENKINS & SONS C YORK RD MONKTON, MD. V aua 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Qnset and Death** Immediate Cause (Final Cell Physician Cancer ear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 🗌 No robably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 After this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 200 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 1 ☐ Yes 1 | Inpatient ۴ 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier

State

SEP 3 0 2008 Registrar

ROBERT DONEGAN

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 23. 2008 4:51PM September Robert E. Moran, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1**X** M 2□ F September 27, 1929 Washington, D.C 78 Director 578-40-3942 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show rai", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Pages 1 and 2 should be filed within 72 hours after death with t nent of Health and Mental Hygiene. 20854 United States 9410 Kendale Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces 1 □Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Š 3 ☐ Widowed 4 ☐ Divorced White "natural" permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Psychiatry Psychiatrist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jocelyn Beard မ Robert E. Moran, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 20854 9410 Kendale Road, Potomac, Lillian L. Moran/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State September 2008 27, 2008 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M00335 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardry disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him reduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Careliovascular 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 XNo or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ZER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September, 23, 2008 D0044394 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 oil George town Road, Bethesola, Mayland 2084 31. Date filed (Month, Day, Year) 82. Registrar's Signature 30 2008 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		rtment of H			jiene _{leg. No.} 2	008	31	174
	Dhusisi		1. Decedent's Name (First, Middle, Last)			2. Date of D Month						
	Physicia /Medic		Marianne Me	eszoly				September		2008	3:45	p ^M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. Co	unty of Death		
ar [*]			Brighton Gardens 5. Social Security Number 6. Sex	7. Age (In yrs. la	et hirthday)	If Under 1 Year	Rockville If Under 24 Hrs.	8. Date of Birth		ontgom	ery place (State o	r Foreign
	Funeral Director			M 212 F 96	Yrs.	Months Days	Hours Min.	May 8,	; Year)	Cou	ntry) gary	i i Greign
			Usual Residence of Decedent	1 30				may 0,	1912			
	show	_	10a. State 10b. County	10c. City	Town or Loc	cation				1	10d. Inside Cit	·
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7	should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, Ite Modical Examinatment to inciting a		17. Father's Name (First, Middle, Last)	4		Secretary	18. Mother's Nam	e (First, Middle,		strial mame)	Tools	
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Ž	and 2 salth a 1.27 is		Peter Meszoly/ Son	L.	5833	Plainviev	v Road, B	ethesda	Mary	land 2	20817	
<u> </u>	es 1 a of He of He fitem	1 25	20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of natory or other place	i	Date		ion - City or To		
Ĕ	Pag ment ant: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovar from State		Crematorium	, Depen	mber 25,	Beth	esda,	Marvla:	nd
Dalillinor	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral Service License	M01532	Ro 75	Name and Addres bert A. P 57 Wiscor	s of Facility umphrey Fur	neral Home				III-
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5	the a	/sici	1 ☐ Yes 2 🏝 No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5□	Other (specify)				Month	Day \	Year
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<u>~</u>	or At ther of irec n by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tow		lumber or Run	al Route Num	ıber,
ב	spital or ours afte teral Dir filled in		29a. Certifier 1 Certifying Phys	sician: To the best of my know	vledge death	occurred at the tin	ne date and place	and due to the	nalice(c) ar	nd manner as	etated	
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			30 Name and address of pelsøn who co	mpleted cause of death (Item	23a) (Type,				٥٠١	- Dumbel		220
	2		Dr. Gary E. Raffel	M.D., 11119 I	Rockvi	lle Pike	Ste.316,	Rockvill	e, Ma	ryland	20852	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat		N. N.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}₂₆, **Physician** SEP Daniel Elbert Patrick 2008 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 283 Riverside Dr Anne Arundel Pasadena 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months 1**X** M 2□ F 212-40-8204 66 SEP 19, 1942 Maryland Usual Residence of Decedent MD State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Pasadena Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 283 Riverside Dr 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No 1960—
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1962 White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Machine Manufacturing 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Patrick Edna Frye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel E. Patrick, Jr./Son 283 Riverside Dr Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 9/27/08 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility
Cremation Society of Maryland,
299 Frederick Rd Baltimore, MD Caro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Month VON ue to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Physician /Medical Examiner Examiner and requires that the death certificate be execu

Funeral

Director

show

ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f sho Injury or other traumatic event, the Medical Evant natural by notified at

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than

permit. Pages 1 Department of I-Important: If ite any Injury or ot

2 should be fi and Mental F

within 72 hours after death

Baltimore, Maryland 21215-0036

burial attending physician for use as the buria the à s been signed E should be deta has e 2 s page certificate

Box 68760,

P.O.

Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica After th funeral s after death.

I Director: 4
d in by the for

within 24 hours a

To the Funeral C

completely filled

State

29b. Signature and title of certifier

3 ☐ Suicide

29a, Certifier

Medical

4 Homicide

6 Could not be

and manner stated

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOVER

31. Date filed (Month, Day, Year) SEP 3 0 2008 32 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 5:52 p ^M 24, 2008 Ruth Purce11 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carrol1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec 21, 1912 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Director 214-01-8094 95 Mary land Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be men whom the construction of Health and Mental Hyglene.

Department of Health and Mental Hyglene important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner. 1 TYes 2K No Director MD Carrol1 Westmisnter 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1220 Nottingham Road 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify. 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 + Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth Be Charles Edwin Green ౖ Myrtle Ruth Lafferty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry R. Zentz Daughter 1220 Nottingham Road Westminster, MD 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Druid Ridge Cemetery 9/27/08 Pikesville, Maryland 21. Signature of Fuheral Service Licensee

22. Name and Address of Facility

11824 Reist

ELINE FUNERAL HOME Reister

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11824 Reisterstown Road Reisterstown, MD 21136 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 mon THS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown þ signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 □ Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page certificate ! 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUSE 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Records, Division or Vital the Hospitai

6

Medical

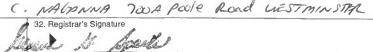
State Registrar

C-OURISIADNEAR 31. Date filed (Month, Day, Year) SEP 3 0

29b. Signature and itle of certifier

29a. Certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO059552

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edith Pierce September 23, 2008 7:45 PM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F Director 220-22-0844 84 24, 1923 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21085 **USA** 907 Philadelphia Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Machine Operator 12 Shoe Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Ramsay Smith Miriam Hulda Norris ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra Darlene J. Sturgill/Daughter 1704 Ridge Road, Whiteford, MD 21160 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Lut. Ch. Cem. 9-26-08 4 Donation 5 Other (Specify) Joppa, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Sign in e Funeral Service Licenses un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jersis Physician disease or condition resulting in death) 1 day /Medical Due to (or as a consequence of): Examiner 1.2da Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 ☐ Other (specify) been signed by the a should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension page 2 s performed this certificate 1□ Yes 2☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA r 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIE

SEP 3 0 2008

31. Date filed (Month, Day, Year)

TIMMEY

32. Registrar's Signature

D53186

and U15 W. MacPhail Rd., Suite 106 Beldir, mo 21014

September 24,2008

Examine Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at across once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 64

Physician /Medica

1 - State				State of Ma	ryianu		ertificate			Merita	ai mygiei Reg.	- 7 11 11 8	3	178
1. Deced	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										3. Time o	of Death		
Joyce Rector										Septe	enber 2	7, 2008	6:50	РМ
4a. Facility Name (If not institution, give street and number)									ocation of Death	h		4c. County of Dear	th	
		ey Stre					Balt					N/A		
5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 M 2X F 64							y) If Under 1 Months		If Under 24 Hrs. Hours Min.	8. Dat (Mo Marc	te of Birth Onth, Day, Ye Ch 8, 1	944 West	thplace (State buntry) Virgi	
-	a. State 10b. County 10c. City, Town or Location										10d. Inside (City Limits		
		Balt	imor	e l		unda							1 ☐ Ye	s 2[XNo
											Citizen of What Co	en of What Country?		
i	7007 Conley Street 21224 USA													
-	ital Status			2. Was Decedent E	ver in U.S.	13	3. Was Decede	nt of His	panic Origin? (S , Mexican, Puert	pecify Ye	s or No-	14. Race - Ame		
		ied 2XMarri 4 □ Divorced	ied	Armed Forces? 1	0		1 ☐ Yes 2		Specify:	io nicari,	etc.)	Black, Whit	nite	
Flore		15. Decedent cify only highes andary (0-12)	t's Educa	ation completed) College (1-4or 5+		16a. Dec (Giv	cedent's Usual ve kind of work . DO NOT use	Occupa done di retired)	tion uring most of wor	rking	166	. Kind of Business	/Industry	
40	ears	(0-12)		College (1-401 51	<u>'</u>	Hous	sewife					wn Home		
		(First, Middle,	Last)						18. Mother's Nan		Middle, Mai	den Surname)		
Adri	ian Fo	ord							Edna Go	TI				
		ame/Relationsl	hip (Typ	·								ity or Town, State,		
		Rector		Husband	OOL Die	a of Dia	nasitian (Mame	2 of		Date		Maryland . Location - City or		
1 🔯				emoval from State	cem	retery, cr	ematory or oth f Faith (er place	ery Octo	ober	1.	sedale, M		đ
21. Sig	Tature of Fi	ineral Service	License	Con	ell	4	22. Name and Connell 7110 So	Addres y Fi ollei	ineral H s Point	ome (Of Dun d, Dun	dalk,P.A. dalk,Md.	21222	
23a. Pa	art 1. Enter	the disease, of	complic	ations that caused to cause on each line	the death.	not e	enter the mode	of dying	, such as cardia	c or respi	iratory arrest		Approxima Interval B	ate etween
Immedi	iate Cause e or condition	(Final	grilly offic	nan Sv	nall	00	il lux	. 0	Canci				Onset and	Death
resultin	ng in death)	0	a.	Due to (or as a	consequer	nce of):	iv lock	13	00010					07111
_ Seguen	ntially list co	nditions.	b.											
if any, le	ntially list co eading to in Enter Unde (Disease or	nmediate erlying	Į	Due to (or as a	to (or as a consequence of):									
that initi	iated event g in death)	s Last	c.	Due to (or as a	consequer	nce of):								
ž			L											
<u> </u>			u.											
IF FEM 23b. Wa	as deceder	t pregnant	23	Bc. If yes, outcome of	of pregnanc	y eath	3 ☐ Ectopic pre	adnancv				23d. Date of de		
	the past 12 □Yes 2			4 Pregnant at			5 ☐ Other (spe					Month	Day	Year
-	Unknowr				6 m m d : 1-1		and the state of		n in De-t I	00	20 Did tobar	co use contribute t	o the cause o	f death?
Part II.	otner signi	ncant condition	ons cont	tributing to death bu	i not resulti	rig in the	underlying cal	use give	ıınırdı().	23			robably 4	
								_		24	4a. Was an autopsy	prior to	utopsy finding completion of	is available f cause of
3											performer □Yes 2	No 1 □Ye		
exa	miner?	rred to medical	_	ospital:				Othe	26. Place of De			0 Florit - 1 (0)		
	Yes 2	No th		28a. Date of Injur	y 2	3/Outpat 8b. Time	tient 3 DOA	Sc. Injury	at Nursing F	1	4	e 6 Other (Sp.	ecify)	
11/2	Natural	5 ☐ Pendin investig	ng gation	(Month, Day	(Year)	Injur	y M	Work	? ′es 2 □ No					
2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farium building, etc. (Specify)							street, factory,	office		28f. Lo	cation (Streetity or Town, S	et and Number or F	Rural Route No	ımber,
	Homicide			building, etc	. (Specify)						ty of Town, c	nate)		
	ertifier Check only one)	1 Certifyir 2 Medical	ng Phys Examin	ician: To the best of er: On the basis of and manner sta	examinatio	edge, de n and/o	eath occurred a r investigation,	at the tin in my op	ne, date and place pinion, death occ	ce, and du curred at t	ue to the cau the time, date	se(s) and manner a and place, and du	as stated. le to the cause	e(s)
29b. Sig	gnature and	title of certifie	f ()	0 40/ 0-	. ()		29c.	License	number		29d	Date signed (Mor	ith, Day, Year)	108
30. Nan	me and add	ress of person	who cor	mpleted cause of de	eath (Item 2	(Typ	pe, Print)	V CX	110	V -	را)	9/1 27	210	92
31. Dat	te filed (Moi	nth, Day, Year)	NUT	32. Registra	r's Signatur	re &	YUYK		h	une	WUITE	2 FID	410	()
3., 54	SEP 3 0 2008													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 4b,c,26,per dr., g883,09/30/08dhb

10e,16b per FH Certificate of Death

Reg. No. 1 - State Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12'SAM **Physician** ZUCF (ein Anes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Baltimore Northwest If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Country) **Funeral** Days Hours Min 1**□**M 2□F 249-26-2037 Yrs. 8-1924 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Wholeal Examiner is used by notified at 1 Pres 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 1402 E. Coldspring Lane 10f. Zip Code U.S.A 21239 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ No 1 Never Married 2 Married "natural", or Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Indust (Give kind of work done during most of working life. DO NOT use retired) Sherman Williams permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmeit. Elementary/Secondary (0-12) College (1-4or 5+) 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be .vla. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 21224 willie 916 Oldham St. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 9.3.2008 Baltimore, MD Garrison Forest 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vungha C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4405 York Ad Bultimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ned by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) The law requires that the death certificate be P.O. Box 6876 Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. be 1 Yes 2 To 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 🗆 No 1 ☐ Yes 2 DHO 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospice Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes **№** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral dii P 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 1/2 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie us 127, 2008 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Year)

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2008

Segistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ 1205 hrs Medical Examiner GARY REINHOLD CALVERT September 17, 2008 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 3825 Eastern Avenue If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or Social Security Number 6. Sex : 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 219-60-8282 55 11-19-1952 Country) W. Va. 1 X M 2 Usual Residence of Decedent any 10a. State 10b. County IOc. City, Town or Location 10d. Inside City Limits N/A 1 X Yes 2 No 28a-f show MD BALTIMORE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 301 CORNWALL STREET 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married X Yes 2 Nees, Give Year VIETNAM 0 WHITE 3 X Widowed Divorced Yes 2 No specify Specify 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) iten 27 is marked other than MD 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. CONSTRUCTION LABORER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ OUENTIN REINHOLD MARY (LILLY) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic GENEVIEVE BARNSTORS/SISTER 8303 ALLISON LANE ROSEDALE, 21237 MD 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department o **METRO** CREMATORY 9-27-08 CATONSVILLE, MD Donation 5 Other Specify: 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical 23a, ptII,27 per me g884 10-17-08 vt X UNPENDED the attending physician led for use as the burial **AMENDED** Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed by funeral director, page 2 should be detach ğ Yes 2 No 3 Probably 4 ✔ Unknown Chronic Alcoholism Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Division of Vital examiner? Other₄ Hospital: 4 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes OKIND (UA) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Yes 2 No Funeral Director: Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. September 18, 2008 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 45 a.M Joann Richardson 22 1000 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Number **Funeral** Months Days Hours Min 1 □ M 2 □ **y** 219-32-9175 Vrs No. Carolina Jun 1, 1937 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County id other than "natural", or Items 23a or 28a-f show event, It a Madical Examinar must be nothed at 1 □ **X**es 2 □ No Director Baltimore **Baltimore City** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 21229 503 North Dennison Street Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify. Black <u>۾</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Mobley **Emmanuel Mobley** ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 2006 Woodlawn Drive Baltimore, Maryland 21207 Michael Sharp other t permit. Pages 1 and Department of Heali Important: If Item 2 any Injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Bodrial 2 ☐ Cremation 3 ☐ Removal from State 09/26/0B Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Park 21. Sonature of Funeral Prvice Lice vee 22 Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final THEROSCIEROTIC **Physician** CORUNARY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be exec Due to (or as a consequence of) vision of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 2 No 1 □ Yes the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director; After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

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2008

31. Date filed (Month, Day, SEP 3 0

	_ For	State of M	•	-			vientai Hy	giene			
	1 - State Registrar			Cei	tificate of	Death		Reg. No.			
1- State 1- State											
	4a. Facility Name (If not institution.	give street and number	·)		4b. City, Town, o	or Location of Death	1	1			
er				J	Baltin	1050		N/A			
	5. Social Security Number	6. Sex 7. A			If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th Vear	9. Birthplace (State or Forei		
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Oire	10e. Street and Number							10g. Cit			
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ne	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. ?	13.	Nas Decedent of his fixes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.))			
		ed 1,XCTX/es 2. ☐ If Yes, Give] No		I∐Yes 2≹ No	Specify:			Specify:	lubi to	
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ם	Elementary/Secondary (0-12)	College (1-4or	5+)			(d)			Manuf	acturing	
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Description Reg. No. Section Reg. No.		actui riig									
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			неттие								
Ų.	21. Signature of Funeral Service I	to Pur	8//							· ·	
	23a. Part 1. Enter the disease, or	complications that cause	ed the death. Do	not ent	er the mode of dyi	ing, such as cardiad	or respiratory a	rrest,		Approximate Interval Between	
	Immediate Cause (Final	_								Onset and Death	
	disease or condition resulting in death)	a			D126074	<u>. </u>					
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ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence	of):							
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<u>cial</u>	In the past 12 months?					cy			Month	Day Year	
WSi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown									
		ns contributing to death	but not resulting in	the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute	to the cause of death?	
							10	Yes 2	□ No 3□	Probably 4 Unknow	
ete							24a Was	an	24b. Were	autopsy findings available	
dm	-						auto	psy	prior t death	to completion of cause of 1?	
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$\mathbf{\omega}$	examiner?	Hospital:				har:					
ို		1 La Inpa			IL 3 LI DOA	4 Li Nursing F	1			pecify)	

Physic /Med Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

(Month, Day, Year) Injury Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

10

Medical Certification

State

Registrar

Baltimore

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sarah Mur 31. Date filed (Month, Day, Year) 22 S. Greene St Murthi

SEP 3 0 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR G883 9/30/08 TT
State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 25 2008 \mathbf{a}^{M} 5:50 Edna Sansosti Dorothy 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Manor Care Ruxton Baltimore Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Maryland 8. Date of Birth
JUL 19 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 2**X**F Months Days Hours 82 Yrs 220-12-9348 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7100 N. Charles Street 21204 11. Marital Status 12. Was Decedent Ever in U.S. Aπned Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Duvall Edna George н. Μ. Zepp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Hayes - niece 3617 Parkhurst, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/29/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams 22. Name and Address of Eacility. Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)25662

29d. Date signed (Mpnth, Day, Year)

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the this certificate has Physician: After t Hospital or Attending within 24 hours a

ng physicien and es the burial-transit sete has been signed by page 2 should be detacl Director: / filled in by

Physician

/Medical

Examiner

10a. State

Funeral

Director

r then "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or iten any injury or other traumatic event, the Medical Examin

Physician /Medical

Baltimore, Maryland 21215-0036

Directo

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Be Completed

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Be Completed

Certification: To

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4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

deeth with the Maryland

State Registrar

31. Date filed (Month, Day, Year) SEP 3 0 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	1	Please L State Registrar	Type or Pring State of M		Depa	delible Ink. artment of F rtificate of I	lealth and	_	gien	_	31184
Physicia /Medica		Decedent's Name (First, Middle, La. Harold	R.		Sa	amuels		2. Date of De Month September	eath		3. Time of Death 9:01 A M
Examine Funeral Director		4a. Facility Name (If not institution, giv Johns Hopkins – Ba 5. Social Security Number 219-01-1086	ayview Cer			4b. City, Town, or Baltimo If Under 1 Year Months Days	re	8. Date of Bi		9. Bird	thplace (State or Foreign cuntry)
D	.	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo:	re	10c. City, To	own or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. Interportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examiner must be notified at once.	ial D	10e. Street and Number 1528 Leslie Road 11. Marital Status	12. Was Decedent	Ever in U.S.	13 \	10f. Zip Code 212		Specify Yes or N		itizen of What Co USA 14. Race - Ame	
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Pages 1 and 2 shent of Health and Int. If Item 27 is niry or other traun	-	19a. Informant's Name/Relationship (Helen Samuels 20a. Method of Disposition	Type. Print) Wife	1	528 1	ng Address (Street Leslie Ro sition (Name of	ad, Dunc	dalk,Mar	ylan		2
iit. Pages artment of ortant: if it injury or o	-	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licer	⁵ y)	ceme	s of I	ratory or other place Faith Cerret	ery 2	ber 1, 008	Ros	edale, M	Maryland
perm Deps impo any i		buthour	1 Cov	Mel of the death of	7	Name and Addre Onnelly F 110 Solle	uneral Fers Point	Home Of 1 Road, 1	Duno Duno	lalk,P.A. lalk,Md.	21222 Approximate
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bur icia	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence							
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de		Ectopic pregnanc Other (specify)	у			23d. Date of de Month	livery Day Year
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification:	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not b determined	e 28e. Place of In	ay, Year)	o. Time of Injury	Wor	y at {? Yes 2 □ No	28d. Describe 28f. Location City or To	(Street a	and Number or R	ural Route Number,
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To th withir To th comp		29b. Signature and title of certifier Edd Num J		mn			65440			c) /2 4/18	
10		30. Name and address of person who	completed cause of	death (Item 23	a) (Type,	Print) Philadila	Lin Rd.	5-, 4 108,	Be. 1	hara, mo	2/237
Stat Registra	r	30. Name and address of person who Le Levy 6. 31. Date filed (Month, Day, Year) SEP 3 0 21	008 32 Regist	ars signature	Ro	sulle					

08-07074 Iaroslav Smetanio	uk	Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hyg	Are Leg	ible.	
	1 F	For State Certificate of Death		2008	3 1 8 5
Physiciar Medical Examin	er	Iaroslav Smetaniouk		Day Year 15, 2008	1826 hrs
(5)	ľ	Ha. Facility Name (if not institution, give street and number) Howard County General Hospital 4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 215-35-9602 1X M 2 F 54 Yrs. Months Days Hours Min.	8. Date of Birth 2-23-19	9. Bir 954 Foreig	
any	<u> </u>	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	<u> </u>	3110 Orlando Avenue 21234		o- Perm. Re	
eath with items 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R		14. Race - Amer White, etc.	ican Indian, Black,
safter de	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced of Yes, Give Year or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo	ork done	Specify:	White
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Montal Hygione. Important: If item 27 is marked other than "natural", injury or other transmatic event, the Medical Examiner.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire		1.	industry
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MD 21 d 2 should the and Mer n 27 is mar] د	19a. Informant's Name/Relationship (Type, Print) Taras Smetaniouk Son 19b. Mailing Address (Street and Number or Rumannia Smetaniouk) 3455 Pine Haven Circles			
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1	4 Donation 5 Other Specify: St. Michael Ukranian Cem 9-		B Dundall kFuneral Ho	
Depr.	4	Syphie Rinker 1 9705 Belair Rd. No	attingh.	am. Md., 2	1236
Physician /Medical aminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	respiratory arre	st, snock, or near	Approximate Interval Between Onset and Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.			
6 E =	edical	UNPENDED AMENDED			
or use	sician/I	IF FEMALE: 23c. If yes, outcome of pregnancy 1	ncy	23d. Date of delive Month	ry Day Year
P.O. E	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	-	bacco use contribute to	
rds, Frequires			24a. Was a	an 24b. Were a	outopsy findings available completion of cause of
of Vital Records, ig Physician: The law requirement of the this certificate has been some all director, page 2 should	Completed			med? death?	
ital Fician: Secrific	8	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3 DOA Other4 Nursing	J	Residence 6 Oth	er:
Sion of Vital Records, P.O. Attending Physician: The law requires that the recath. ector: After this certificate has been signed by by the funeral director, page 2 should be detach.		28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred from tree stand	
Division tal or Attendi rrs after death. al Director: /	Certification.	Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City
Div spital or fours after or filled in	Cert	Tomicae	-	ory Road, West Frie	
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fil	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and cone 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.			
7. № F 3	ĕ.	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (M September 16,	
4		Natrucia Urgnica Follok no O.C.IVI.E. 30. Name and address of person who completed cause of death (Item 23a)		Joptoniber 10,	
り		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 2120	1	
Sta Registr		31. Date filed (Nonth, Day Xeer) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 95-PT 27 5466 A M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIE BALTIMORE (-LEN ANNE ARUNDEL MEDICAL WASHINGTON CENTER 8. Date of Birth (Month, Day, Year) Nov • 29 , 1931 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days Hours 118-24-8938 76 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show clical Examinar must be notified at 1 □Yes 2 No Director MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7959 Telegraph Road #9 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼19/es 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □ Yes 2X No Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Animal Control Officer County Government marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file timent of Health and Mental H tant: If item 27 is marked out Be Carl Sugg Isabelle Nunz 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Charles Sugg/Son 964 Annapolis Road Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct. Date permit. Pages 1 Department of H = 5 1 Burial 2 □ Cremation 3 □ Removal from State Important: If any Injury o 2008 Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services 1 2nd Avenue SW Glen Burnie, MD 21061 MOIIZI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORDNARY **Physician** DISCHSE ALTER disease or condition resulting in death) VEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, as the IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ğ Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 TUnknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 **X** No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 🔲 Inpatient 2 ER Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

301 HOSPITAL Registrar's Signature

29c. License number

GEN BURNIE.

SEPT

2106

29d. Date signed (Month, Day, Year)

2008

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 10:30 2008 SEPTEMBER **Physician** R SIMPSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE, MARYLAND HUSPITAL HARBOR 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 02-17-1921 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 5. Social Security Number Hours Days **Funeral** MD 1 □ M 2 1 F 87 219-01-0596 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State 1 ☐Yes 2 No Glen Burnie Directo Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21061 102 North Crain Hwy, Apt. 970 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: white 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: Baltimore, Maryland 21215-0036 <u>م</u> 3 ☐ Widowed 4 1 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) KMart 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Catherine Curtin Robert Samuel Brady ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 831 Dover Court Place, Downingtown, PA 19335 Mr. John M. Simpson / son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Glen Burnie, MD 09-29-2008 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) FROM HIP FRACTURE DAY COMPLICATIONS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner TOW APPROVED BY MEDICAL CHAR The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day detached for in the past 12 months?
1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by: 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 👿 No 3 Probably 4 Unknown 1 🗆 Yes FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No REPLACEMENT MITTRAI s certificate has blirector, page 2 s 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25 Was case referred to medical director, Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Yes 2 🗆 No this Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After thi funeral of 28b. Time of 27. Manner of Death Injury 1 ☐ Natural 2 Accident 5 ☐ Pending investigation DEPTERBUR 25 2008 UNKNOWN M 1 ☐ Yes FELL AT HOME 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after death e Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 4 Homicide 62 N- Crantitu NOTON 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

within 2

State Registrar

3001 MUSPITAL 31. Date filed (Month, Day, Year) SEP 3 0 2008 32. Registrar's Signature

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

SOUTH drack 29c. License number

RESOOO

MANDUER STREET BALTIMORE MARILAND

29d. Date signed (Month, Day, Year)

SEPTEMBER 26 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death September 29, 2008 Year **Physician** 1:20A JOYCE HELEN SHARPLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Timonium Stella Maris | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. June 2, 1934) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Funeral 1 □ M XX F Mary I and 74 218-32-7116 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event and be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 □ Yes 2√√No Director Baltimore Timonium Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 LISA 2300 Dulaney Valley Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tes 2XX If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2**XX**No White Specify: Completed by ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) H0memaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Joyce Edwin Coogan ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul W Sharpley Jr 3006 North Branch Lane Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ☐ Burial 2XXCremation 3 ☐ Removal from State Green Mount Crematory 10-1-08 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wie efeld Funeral Home Inc Ignature of Funeral Service Lice 6500 York Road Baltimore, Maryland 21212 nnis Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** POWS disease or condition resulting in death) emer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) Pregnant at time of death 9 Unknown been signed by i should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an certificate has page 2 autopsy perform 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Inpatient After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, within 24 hours after death To the Funeral Director: Hospital

Maryland 21215-0036

Baltimore,

2008

SEPTEMBER

SHARPLE

JOYCE

State Registrar

ERNESTINE WRIGHT, 31. Date filed (Month, Day, Year)

29b. Signature and title of certified



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

29 1200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien \mathscr{L} igcupCertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 40 (M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Care Center Parkville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, July 13, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** .^{Ye}3(⁾922 Days 1 □ M 2 🔽 F July 204-03-0334 86 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Parkville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8832 Walther Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. purmit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hydjene. Important: If Item 27 is ansked other than "natural", or item any Injury or other traumatic event, the Medical Examiner 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋No þ Specify Specify: White 3X Widowed 4 □ Divorced ear or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Baker Elizabeth Poeth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai 574 Wildflower Trail, Myrtle Beach, SC Thomas Swank-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 09/29/08 Dulaney Valley Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** demen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate ha irector, page 2 Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certification: To 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month. Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signal (7)e and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Fraure All Copies Are Legible.

amend item 19a per in 8883 Ph. 3 Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 11:50 AM September SCHERR 2008 IRENE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City Sinoi Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/05/1914 Birthplace (State or Foreign Country)
 M.D. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 K F Months Days Hours MD 93 216-09-0319 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Modical Examinar must be notified at once. 10a. State 1 ☐ Yes 2 No BALTIMORE Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21208 3800 OLD COURT ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. WHITE 1 Never Married 2 Married 1 □Yes 2 No Specify: Maryland 21215-0036 ģ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL DEPARTMENT SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEAH SCHERR HERLING ISAAC ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. la Arct Name/Relationship (Type. Print) 7020 CHANNEL VILLAGE CT., #T1, ANNAPOLIS, MD MARCIE KENNAI / DAUGHTER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place. Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 09/28/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic shock 万り **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Celluli Tus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Chronic veno - cultural intrifficience that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours af e Funeral D letely filled in 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hore To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Canadouen, MD Soptember 26, 2008 RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Baltimore PAUN, ND Sinoù DANA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 3 0 2008 Registrar

RNOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 P **Physician** 5:25 AM 2008 MILTON SCHLENOFF /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 03 Beltimore HOSDITZ of N/A Milton Schlenst If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, 7. Age (In vrs. last birthday **Funeral** 1 X M 2 1 F Months Days Hours Director 217-22-7956 81 06/07/1927 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show event, the Medical Examiner must be notified at 1 X Yes 2 No Director MD BALTIMORE N/A 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 7111 PARK HEIGHTS AVENUE, #411 "natural", or Items 23a 21215 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ PHYSICIAN MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SCHLENOFF. LILLIAN SPARCK မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 she Department of Health and Important: If Item 27 is m any injury or other traum SELMA SCHLENOFF / WIFE 7111 PARK HEIGHTS AVENUE, #411, BALTIMORE, MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, remaining pother place) MEMORIAL PARK Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 09/29/2008 RANDALLSTOWN, MD 4 Donation 5 Dother (Specify) SOL LEVINSON & BROS., INC. 21. Signatule of Juneral Service Dicense 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Potensive **Physician** 4 day resulting in death) /Medical Ar as a consequence of) **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760fg Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed has been Heart 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a, Was an autopsy fail ore this certificate -i Ver 2 No 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury (Month, Day Year) 1 Natural 2 Accident To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 ran 31. Date filed (Month, Day, Year) SEP 3 0 2008

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. \angle 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 0558 AM SEPTEMBER 28 2008 SAHM LEROY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDALLSTOWN HOSPITAL BALTIMORE NORTHWEST If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 M 2 ☐ F 12/29/1933 MD 74 215-30-9155 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 6 POMONA NORTH, APT. 7 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married or. WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: ρ 3 ☐ Widowed 4 🏋 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED FOOD SERVICE injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be MERVIS SAHM DOROTHY LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17303 STAG HORN COURT, GERMANTOWN, MD STEVEN SAHM / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/29/2008 BALTIMORE, MD BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ VENTRICULAR TACHYCARDIA, PULMONARY ARTERY STENOSIS 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No PULMONARY ARTERY ANEURYOM, ATRIAL FIBRILATION 24a. Was an autopsy AURTH AND MITRAL VALVE REPUBLICADY, CHRONIC CASTRUCTURE PULLY DISCORE 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 28d. Describe how injury occurred 28a Date of Injury 28h. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) or Attending LE Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 64957 SEPTEMBER 28, 2008 NILIAM Patel MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, RANDALLSTOWN, MD 21133 4 NORTHWEST NILESH PATEL, MD 31. Date filed (Month, Day, Year) SEP 3 0 2008 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ROY

08-07336 Paul A. Tatar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 31193

	1- For State Certificate of Death Registrar	Reg. No.
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year 1330 hrs
Medical Examiner	Paul Alexander Tatar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	September 20, 2006
	3257 Elmede Road Ellicott City	Howard
Funeral Director	5. Social Security Number 215-82-6154 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24F Months Days Hours. M	Foreign
	Usual Residence of Decedent	
d fow any	10a. State 10b. County 10c. City, Town or Location MD Howard Ellicott City	10d. Inside City Limits 1 Yes 2 X No
the Maryland or 28a-f sh iffied at once	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	3257 Elmede Road 21043	USA
or items 23 inust be no	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	
safter de rral", or niner my	3 Widowed 4 Divorced If Yes 2 X No II Yes 2 X No specify:	Specify: White
natural Examin	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use r	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "matural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	2 Manufacturing	Clothing
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	17. Father's Name (First, Middle, Last) Alexander Tatar 18. Mother's Na Glad	me (First, Middle, Maiden Surname) ys Burnham
ould be fill to a marked tic event,		or Rural Route Number, City or Town, State, Zip Code)
e, MD : I and 2 sho Health and item 27 is r traumatin	Matthew Tatar, brother 13014 Prairie Knoll	Ct, Germantown, MD 20874 Date 120c. Location - City or Town, State
Baltimore, permit Pages I at Department of Hee Important: If ite injury or other tr	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	
Baltimoru permit Pages I Department of I Important: If	4 Donation 5 Other Specify: Metro Crematory, Inc. 9/ 21. Signature of Funeral Service I General Oring 22. Name and Address of Facility 22. Name and Address of Facility 30. Cie	
Balti permit Departr Imports injury o	299 Frederick R	ty of Maryland, Inc. oad, Baltimore, MD 21228
Physician //Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	c or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Tramadol intoxication Due to (or as a consequence of):	2000
<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted Insit Examinet	Chicago or injury that initiated	
and - transit	events resulting in death) Last Due to (or as a consequence of): d.	
760, cate be execu physician and the burial - tr	X UNPENDED AMENDED 23a,27,28a-f, perME, g885 11,	6/08 TT
8760, ifficate be ng physici is the buri	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	23d. Date of delivery gnancy Month Day Year
, P.O. Box 687 ires that the death certific isgned by the attending. Ube detached for use as I do by Physician!	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
D. Bc t the dez by the a ached fo	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach errification: To Be Completed by Perfification: To Be Completed by P		1 Yes 2 No 3 Probably 4 Unknown
cords law requi		24a. Was an autopsy prior to completion of cause of death?
tal Records, sian: The law requires certificate has been signetor, page 2 should be Be Completed		1 Yes 2 No 1 Yes 2 No
/ital sician: sicien: director	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	rsing Home 5 Residence 6 🗸 Other: Scene
of Vi ing Physi After this funeral dir	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
livision I or Attendi after death. Director: d in by the f	Natural Accident Pending Investigation Fnd 9/26/08 Fnd 1:15 pm 1 Yes 2 X No 28e. Place of Injury - At home, farm, street, factory, office building, etc.	unk
Division o spital or Attending tours after death. neral Director: Aft filled in by the functor:	Suicide 6 X Could not be determined (Specify) house	28f. Location (Streets and Number or Rural Route Number, City or Town, State) 257 Elmede Kd
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated.
To the Ho within 24 To the Fu completel:	one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b∧Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	September 27, 2008
5 0500	30. Name and address of person who completed cause of death (Item 23a)	
5	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🛭 Certificate of Death 2. Date of Death Month 1. Decedent's Name, (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Anne Arundel Glen Burnie Baltimore-Washington Medical Center 9. Birthplace Country) Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Days Hours Months 1**∑** M 2□ F June 21 1921 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 □Yes 2 No Glen Burnie Director Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21061 7975 Crain Highway Apt. 413 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 √ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 □No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Firefighter Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic eve Thompson Trebes ၉ Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

7975 Crain Highway Apt 413 Glen Burnie, Maryland 210 1

20c. Location - City or Town, State Margareta Trebes (Wife) 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/01/08 22. Name and Address of Facility 21. Signature of Fuperal Service Licensee McCully-Polyniak Funeral Home, P.A. Patansco Avenue Baltimore, Maryland 21225 23a. P. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. urcha Immediate Cause (Final DU **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed 2 No 1 TYes 2 H100 certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 ₩ No မ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide estifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of sertifie 30. Name and address of (Item 23a) (Typ, Print) Madel 32. Registrar's Signature 31. Date filed (Month, Day State 30 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 25 Year 2008 **Physician** THOMAS 8:50 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FOREST \mathtt{HILL} HARFORD 2908 SMITHSON DRIVE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2√2 F 85 Yrs. 218-80-2607 MARYLAND Director 7-10-1923 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
amt: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is the filed Examination must be confined at ury or other traumatic event, it is the filed Examination. 1 ☐ Yes 2 XNo ROSEDALE Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21237 U.S.A. 8030 OLD PHILADELPHIA ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: ð Specify: WHITE ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (WEITZEL (CLICHAM) CLARENCE HELEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PATRICIA SEIBERT/DAUGHTER 2908 SMITHSON DRIVE FOREST HILL, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 9-29-2008 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service License 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Par D Death Immediate Cause (Finel **Physician** disease or condition resulting in death) /Medical sequence of): ERCITOUST REMIX Examiner Equantiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a consequence of): Due to (or as The law requires that the death certificate be executed ng physician and as the burial-tran P.O. Box 68760,54 resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months 5 Other (specify) 1 ∐ Yes 2 🗓 🗤 o detached 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sh autopsy performed

1 Yes 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) DAUGHTER † S 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? HOUSE 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific M Chesaco Ave, Belto, M721237 30 Name and address of person who completed ause of death (Item 23a) (Type, Print) N. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

30

2008

ORIGINAL

			For State Registrar	State of Mary	riand / De <i>C</i>	partment of H <i>ertificate of L</i>	leaith and iv D <i>eath</i>	ıentaı Hyg	giene Reg. No. 200	8 31196					
	Physici	an	1. Decedent's Name (First, Middle, Last, John Wallac					2. Date of Dea	Day Ye	3. Time of Death ar 11:59 P.M					
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	Septem	4c. County of E						
			Gilchrist Hospi			Towson			Balti						
	Funeral Director			7. Age (Ir	79 Yrs. last birthda	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 2/25/	h y, _{Year)} 9. 1929 Ма	Birthplace (State or Foreign Country) ASSACHUSETTS					
~	land ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location			-	10d. Inside City Limits					
1159 AM	e Mary Ba-f sh	Director	Maryland Baltimor	e	I	utherville	:			1 ∐Yes 2√∑No					
1150	ath with th	ral Dire	10e. Street and Number 45 Southwark Brid	ye Way		10f. Zip Code 210			Of Arneri	.ca					
Sept26,2008 5-0036 1159	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "natural Exa nit or must be profilled at	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Xres 2 No If Yes, Give Year or Dates:			Specify:		Specify:	American Indian, Vhite, etc. White					
קי	within 72 ho piene. r than "natur Irs Medical	Completed	15. Decedent's Edu (Specify only highest grad		16a. De	cedent's Usual Occupa ive kind of work done of e. DO NOT use retired	ation during most of worki f)	ng	16b. Kind of Busine United	*					
21		Com	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ter Sergea	nt		Army	7					
TH55 aryland	be od o	To Be	17. Father's Name (First, Middle, Last) Albion R. Thi	ssell			Elizab	eth A.M	Maiden Surname) 1. Suith						
Σ	nd 2 sho alth and 27 is m r traum		19a. Informant's Name/Relationship (Ty Debra L. Thissell	_{te, Zip Code)} 21093 Maryland											
्री लीप्त Baltimore,	permit. Pages 1 au Department of Her Important: If item any Injury or othe		Debra L. Thissell/ daughter 45 Southwark Bridge Way Lutherville, Ma 10a. Method of Disposition 1												
Bal	permit Depar Impor any In		21. Signature of Funetal Service Licens	e A	15	aceful Adre 2325 York	ternative Road T	s Funer imonium	al &Crema , Marylan	tion Ctr.,P.A d 21093					
	Physician		2325 York Road Timonium, Maryland 21093 23a. Fart 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between Onset and Death (Sease or condition resulting in death) Due to (or as a consequence of):												
	/Medical Examiner	Jer		Due to (or as a co	nsequence of):					O					
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P.O. Box 6	attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у		23d. Date o Month	delivery Day Year					
ds, F	w requires that the d been signed by the should be detached		Part II. Other significant conditions cor	ntributing to death but no		underlying cause give	en in Part I.			te to the cause of death? Probably 4 Unknown					
Division of Vital Records,	The law req tte has beer age 2 shou	Completed by	RECENT CE	REBROVA	SCULA	r bie	NT/CVA	24a. Was autop perfo	osy prio rmed? deal	e autopsy findings available to completion of cause of th? Yes 2 □ No					
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J of	g Phys ter this neral di	n: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day, Ye	2 ER/Outpa 28b. Time (ar)	of 28c. Injur	y at		dence 6 Mother (now injury occurred	Specify) HOSPICE					
visior	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury -	At home, farm,	M 1 □	Yes 2 □No	28f. Location (5	Street and Number of	or Rural Route Number,					
Ö	spital or ours afte neral Dir filled in		4 El Torricide	building, etc. (S sician: To the best of m		eath occurred at the tir	me. date and place.	City or To'v		er as stated.					
	thin 24 h	Medical	(Check only one) 2 Medical Exami 29b. Signature and title of certifier	ner: On the basis of exa	amination and/o	r investigation, in my o	pinion, death occurr	ed at the time,	date and place, and 29d. Date signed (A	due to the cause(s)					
	5 1 6 00	_	MendalR	Faille	eus	Da	5643		09/27/	3008					
	1 1/		30, Name and address of person who co	MPTMD/500	SW.TA	weartown	Blud/	Boet	OMO	21204					
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DHMH 17 Rev 1/2001

For

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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, "he "natural Evan" is not be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 10 Stat

		1 = State Registrar				Ce	rtificate of	Death			Reg. No.	000	31197
	4,	1. Decedent's Nam	e (First, Midd	le, Last)						2. Date of De		Voor	3. Time of Death
Physici Medi¢/		LENOR/	Į.			7	RAGER			SEPTEM	BER 26	2008	9:35A [™]
		4a. Facility Name (If not institutio	n, give street and n	umber)		4b. City, Town,	or Location	of Death		4c. Co	unty of Death	
		SEASON'S	HOSPIC	E @ NORTI	HWEST HO	SPITAL	RAND	ALLST	OWN		BF	ALTIMOR	E
uneral				6. Sex						8. Date of Bir	th Vear	9. Birthp	place (State or Foreign
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nera y fille			1 Certifyi	ng Physician: To th	e best of my kno	wledge, dea	h occurred at the	time, date a	nd place,	and due to the	cause(s) an	nd manner as s	stated.
e Fu	dic		2☐ Medical	Examiner: On the and ma	basis of examina nner stated.	ation and/or in	vestigation, in my	opinion, dea	ath occur	red at the time,	date and pla	ace, and due to	o the cause(s)
To th comp	Me	29b. Signature and	title of certifie	r			29c. Licer	nse number			29d. Date s	igned (Month,	Day, Year)
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V C4		31. Date filed (Mon	17	20	Registrar's Signs	dure 4				,			
Sta Registr			EP30	2008	Registrar's Signa	1 do	all s						
5,101			but I		ALL STATES	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Day 29, 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year September 2008 6:15A Robert Gillespie West 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Good Samaritan Hospital Baltimore N/A Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days 1 X M 2 □ F 220-28-4812 Virginia July 24, 1933 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 XNo Glen Arm Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12076 Glen Arm Road 21057 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 195

If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1952 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1955 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore County Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Otha West Elizabeth Hassell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12076 Glen Arm Road Glen Arm, Stephen Mark West, Son MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 09/30/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lie Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ischemic CardiomyopA nowwin Due to (or as a consequence of) are Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 200 1 🗆 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

signed by the attending physician and the detached for use as the burial-transit P.O. Box 68760, Physician: The law requires that the death certificate be Division of Vital Records, icate has been si certificate has

Physician

/Medical

Director

Funeral

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Physician/Medical

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Certification:

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madral Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

5+1 State

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 | atural 2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

6 ☐ Could not be

N Calvert

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

WD

29b. Signature and title of certifier muse

29d. Date signed (Month, Day, Year) 3008

31318

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite

31. Date filed (Month, Day, Year) SEP3 0

32. Registrar's Signature

Registrar

Registrar

State

31. Date filed (Month, Day, Year) SEP 3 0 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MINICEA TODOR, MD

RANDALLSTOWN

MA

21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 1:58 PM Month **Physician** Michele Weis 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Towson Baltimore Bilchrist Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. 1 □ M 2 🕱 F Hours 213-72-2025 Director Mary land Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, Its Medical Examination must be notified at 1 ☐Yes 2No Baltinare Directo Maryland 10e. Street and Number Baltimore 10g. Citizen of What Country? 10f. Zip Code Carson Avenue 21214 United States 7614 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Processor Federal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otiles Adelsberger ပ Katherine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Baltimore mD 21234 Department of Health a Important: If Item 27 is any injury or other tra Ct. oromae Katherine Szymanski East 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funcial Chapter

Part Hard 20c. Location - City of Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 KCremation 3 ☐ Removal from State Forest Hill, MD 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Crapel & Cranation Services - Bel ALT
3 DOWNOOD BY Cropel & Cranation Services - Bel ALT
3 DOWNOOD BY COST HILLIAND 21050 21. Signature Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death UNGCANCER Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physician end should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mod 1 Yes 2 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastases 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one)

Records, of Vital Physician: Division

Maryland 21215-0036

more.

Balti

within 24 hours a 9

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 W. Towsontown Blod/ Boelfo MD 21204 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				1 - For State Registrar	State o	f Mary	rland / Dep <i>Ce</i>	artmer ertificat			nd Me	-	giene Reg. N		31201
		Physici /Medio		1. Decedent's Name (First, Middle, L. Elaine Danz Wiede	-							2. Date of De Month Septemi		29,2008	3. Time of Death 5:45 A. M
		Examin		4a. Facility Name (If not institution, ga Oak Crest Care Ce		nber)			Town, or	Location of	Death			County of Dea	e County
		Funeral Director		5. Social Security Number 6.		_	yrs. last birthday	/) If Unde Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da May 21	th ay, Year 192	9. Bi	thplace (State or Foreign ountry)
				Usual Residence of Decedent 10a, State 10b, County			c. City, Town or								10d. Inside City Limits
	:	the Mar 28a-fat	ector	Maryland Baltim	ore Coun	ty	Parkvil	le 10f. Zij	Code			· · · · · · · · · · · · · · · · · · ·	10a. Ci	tizen of What C	1 ☐ Yes 2∑ No
	3	ath with	ral DI	8800 Walther Blv					2	21234			Un	ited St	ates
) EV	980	filed within 72 hours after death with the Maryland Hybjene. Khar than "natural", or Itams 23e or 28e-f ahow ont, the Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	24[≥]No ∕e	r in U.S. 13	. Was Dece If Yes, spe 1 \(\text{Yes} \)		ispanic Orig in, Mexican, Specify:	jin? (Spec , Puerto P	city Yes or No tican, etc.))- 	14. Race - Am Black, Whi Specify:	
721	21215-0	s filed within 72 ho I Hygiene. other then "natur ent, the Medical	ompleted	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12) 12		-4or 5+)	16a. Dec (Giv life.	edent's Usu re kind of wo DO NOT u HOME	rk done d se retired	du <i>ring</i> most (f)	of workin	g	16b. k	(ind of Business OWN HON	
3		s 1 and 2 should be filed I Health and Mental Hyg Itam 27 Is marked oths othsr traumatic event,	To Be C	17. Father's Name (First, Middle, Las William Henry Dar								(First, Middle rie Pi			
W:	Man	nd 2 sho lith and I 27 is me r traume		19a. Informant's Name/Relationship Mr. Howard Ford V		r. (S		-		and Number Blade				or Town, State, Maryla	
3	more,	- 0 -		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec			cemetery, cr Druid R	ematory or (other plac	(e) O	ct. 200	03, 8		ocation - City of	Town, State
77	Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Juneral Service Lice		arr	Pr.	Peacet 2325	d Addre	Ntern Road	ativ	es Fun	eral M,Ma	.&Cremat ryland	ion Ctr.,P.A 21093
E		Physician /Medical		23a. Party Enter the disease or cor shock or hear failure. List onf Immediate Cause (Final disease or condition resulting in death)	_ aV	Enc	death. Do not e	h 3	4. 2		cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
200	t.	eath certificate be executed attending physician and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		insequence of):								
9-5	.O. Box 68	the d	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		inth 2 🗀	Fetal death 3	□Ectopic p						23d. Date of de Month	Nivery Day Year
11	ds, P	luires that the signed by the detact	þ	Part II. Other significant conditions	contributing to de	eath but no	ot resulting in the	underlying	ause give	en in Part I.				use contribute	ro the cause of death?
1	Records,	The law requir sate hes been s page 2 should	Completed									24a. Was auto perfo		prior to death?	utopsy findings available completion of cause of
7 W	Vital	ysician: Th s certificate director, pag	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient	2 ER/Outpati	ent 3 D	Oth	or.		(Check only		6 □Other (Sp.	acity)
5.4		ling Afte fune	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon				28c. Injun Worl		2	8d. Describe			outy)
5		or At fter c Direction by	Certification;	3 Suicide 6 Could not determine	be d 28e. Place buildi	of Injury - ng, etc. (S	At home, farm, s	street, factor	y, office		2	8f. Location (City or To			Rural Route Number,
5	:	To the Hospital within 24 hours a To the Funeral C completely filled	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the iminer: On the band man	best of m asis of exa ner stated.	amination and/or	ath occurred investigation	at the tin	ne, date and pinion, death	d place, a h occurre	nd due to the d at the time,	cause(s	s) and manner and place, and du	s stated. e to the cause(s)
	,	To the within 2 To the comple	Me	29b. Signature and title of certifier	0.		Min	29	c. Licens	e number			29d. Da	ate signed (Mor	-
	•			30. Name and address of person who	completed caus	e of death		6 4 8	16	1/8	0 1	. 14	11:0	1/29/	
		Sta Registr		31. Date filed Worth, Day, Year	32. R	egistrar's	Signature	. Hos	1010	10	rank	ville	M	7/23	7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1- For State of Maryland / Registrar	Department Certificate		•	/giene Reg. No 2008	31202
	Dhysisi	.	1. Decedent's Name (First, Middle, Last)			2. Date of D Month		3. Time of Death
	Physici: /Medic	al	Charles Robert	Wehnert	own, or Locat	9	24 2008 4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give street and number) The Pines Genesis HealthCard			ion of Death	Talbot	401
	Funeral		5. Social Security Number 219-28-4291 6. Sex	irthday) If Under 1	Year If Ur Days Hou	or 24 Hrs. 8. Date of B	irth 9. Bi	rthplace (State or Foreign ountry) MD
	Director		Usual Residence of Decedent			Jan. 2	4,1934	
	arylan show	ž		vn or Location				10d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	MD Queen Annes Ster	vensville 10f. Zip (Code		10g. Citizen of What C	country?
	th with 23a or 1st be	al Di	308 Oregon Road	2.	1666		U.S.A.	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decede If Yes, speci		c Origin? (Specify Yes or N xican, Puerto Rican, etc.) cify:		
Charles Maryland 21215-0036	vithin 72 ho ne. han "natur e Medical I	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during retired)	most of working	16b. Kind of Business	·
d 26	filed w Hygiel other tl		12 17. Father's Name (First, Middle, Last)	Mailer	18. M	tother's Name (First, Middl	Sun Paj e, Maiden Surname)	per
lar	uld be Mental rrked o	To Be	Edward Wehnert		Doi	ris Fern Ayre	es	
Mary	d 2 sho th and I th and I trauma	ľ				umber or Rural Route Num Stevensville		Zip Code)
Wehnert, Baltimore,	Series		20a. Method of Disposition 20b. Place cemel	of Disposition (Name ery, crematory or oth	e of ner place)	Sept. 29,	20c. Location - City of	
ehn altir	permit. Page Department of Important: If any Injury or once,		4 □ Donation 5 □ Other (Specify) At lar 21. Signature of Funeral Service Licensee			discility Singleton	Glen Burni Funeral &	
'≥œ	o a m be		904 waster	Service	s 1 2n	d Avenue SW	Glen Burnie	, MD 21061
	Physician	8 7	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.		of dying, suc	h as cardiac or respiratory	arrest,	Approximate interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence)	demente	لم			ment
	P #	ner	Sequentially list conditions, if any, leading to the form as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events c.					John
mg	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c Due to (or as a consequence	e of):			, 41.49	
8760,	ate be e nysiciar he buri	dical E	d					
Box 6	The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	th 3 ⊟Ectopic pre 5 ⊟ Other (spe			23d. Date of d Month	elivery Day Year
ds, P.O	ires that th signed by the detact	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying ca	use given in F		tobacco use contribute Yes 2□No 3□	to the cause of death?
Sor	v requi	eted	- Linasac aug 1 mg/Mmm			24a. Wa		autopsy findings available
Vital Records,	iclan: The lav certificate has ector, page 2:	Completed				aut	opsy prior to formed death	o completion of cause of
Vita	iclan: certific ector,	Be	25. Was case referred to medical examiner?		10.1	Place of Death (Check only		
	y Phys er this eral dir	٦: T	27. Manner of Death 28a. Date of Injury 28b	Outpatient 3 DO	c. Injury at Work?	Nursing Home 5 Re	sidence 6 Other (Speed how injury occurred	pecify)
sion	ending ath. or: Afte	ation	Month, Day Year) 2 ☐ Accident investigation Company of the comp	Injury M	work? 1 ☐ Yes	2 □No		
Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory,	office		(Street and Number or own, State)	Rural Route Number,
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred a and/or investigation,	at the time, da	te and place, and due to the n, death occurred at the time	ne cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
	To the vithin To the compl	Me	29b. Signature and title of certifier	29c.	License num	ber	29d. Date signed (Mo	nth, Day, Year)
	8		JAN JAO		VV.	7177	7.24.	08
	0		30. Name and address of person who completed cause of death (Item 23a	(Type, Print) Dula	hman	& Lane, E	aston, M	0 21601
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	barte		,	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jason Workman 1240 M 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Maryland Baltimore uvcrsit Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-09-1980 Social Security Number 6. Sex **Funeral** 214-94-4866 Months Min. 1X M 2□ F Days Hours 28 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or hours any injury or other trainmant. 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ▼ No Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7869 Cheverly Lane 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify þ If Yes Give Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Towing Tow Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ricky Samue1 Workman Ann Jorgenson Karen ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen A. Facemire/ Mother 7869 Cheverly Lane Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 09-25-2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation 1 2nd Avenue SW Services Glen Burnie,MD 21061 Paren 101357 23a. Part1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, and failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Medical Briefich Examiner Due to (or as a consequence of) Physician/Medical ERIFICATIV IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown t □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred
Subject injured in motorcycle
Crash. 28c. Injury at Work? IGUSP M 1 Natural 5 Pending investigation 19/2008 1 ☐ Yes

or Attending Physician; The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records. After this illed in by the f within 24 hours a

> State Registrar

Medical

2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

31. Date filed (Month, Day,

30

29b. Signature and title of certifier

6 ☐Could not be

Year

determined

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

32. Registrar's Signature

Stree

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Furnace Branch Aust Wellham Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	tificate of E			ne _{No.} 2008	31204
	Physici		1. Decedent's Name (First, Middle	e, Last)				2. Date of Death Month	Day 2 Year 2, 2008	3. Time of Death 5820 PM
	/Medic Examin		4a. Facility Name (If not institution	4 11 4	Centor	4b. City, Town, or	Location of Death		4c. County of Deat	h
	Funeral Director		5. Social Security Number		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) 9. Birt	hplace (State or Foreign untry)
-	<u> </u>		147-20-5127 Usual Residence of Decedent 10a. State 10b. County		81 10c. City, Town or Loc	eation		Feb 9, 1	1927	New Jersey 10d. Inside City Limits
	a-f sho	ctor	Maryland	Baltimore	100. 011, 10111 01 200		altimore			1 ☐ X es 2 ☐ No
	death with the Maryland ims 23a or 28a-f show ir must be notified at	I Dire	10e. Street and Number 3402 Arellen Court			10f. Zip Code	21207	10g.	Citizen of What Co	untry?
	r death tems 23 er mus	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	If	Vas Decedent of His Yes, specify Cubar		cify Yes or No-	14. Race - Ame Black, White	rican Indian,
-0036	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show ledical Examir et must be ric fifted ≢l	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ied 1 □Yes 2 □ No If Yes, Give Year or Dates:	•	□Yes 2□ N ∕o	Specify:	,	Specify:	Black
2-0	n 72 hol " natur edical l	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	16a. Deced	ent's Usual Occupa kind of work done du O NOT use retired)	tion uring most of workin	16b	b. Kind of Business/	Industry
7 7	withi iene. thar	Comp	Elementary/Secondary (0-12)	College (1-4or 5+	ille. D		pervisor		Bendix (Corporation
Ξ	d d d	To Be	17. Father's Name (First, Middle,	Last) Imes Holman			18. Mother's Name		den Surname) a Holman	
a	2 should be and Menta is marked raumatic ev	F	19a. Informant's Name/Relations						ity or Town, State, 2	Zip Code)
o,	s 1 and f Health tem 27 other tu		Diana Harris 20a. Method of Disposition		20b. Place of Dispos	402 Arelien C		 -	1207 Location - City or	Town, State
Saltimor	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 ts marke any Injury or other traumatic once.		1 □ R urial 2 □ Cremation 4 □ Dopation 5 □ Other (S	3 ☐ Removal from State		atory or other place outh Memoria	. <u></u>	09/26/08	Tinton Falls	, New, Jersey
Da	permit. Departr Importa any Inju		21. Sign ture of Funeral Service	Lixinsed	22.	Name and Address Estep E	s of Facility Brothers Fune utaw Place B	ral Service, P	. A.	
		5 15	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the control one cause on each line	ne death. Do not ente	r the mode of dying	utaw Place B	altimore, Md arrest,	21217	Approximate Interval Between
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to for as a	consequence of):	comou)	a			Onset and Death
e E	Examiner	L	Sequentially list conditions.	b						
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
,00	eain certificate be executed attending physician and for use as the burial-transit	al Exa	resulting in death) Last	Due to (or as a	consequence of):					
00/00	nuncate ng phys as the	Aedical	IF FEMALE.	d						
SO !	Prystotan: The law requires that the death cer this certificate has been signed by the attendir ral director, page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
5	res that the de signed by the a be detached f	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown				T		
cords,	urres th signed Id be de	à	Part II. Other significant condition	ns contributing to death but	not resulting in the un	derlying cause giver	n in Part I.			the cause of death?
	e law requir has been s je 2 should	Completed						24a. Was an autopsy		topsy findings available
וושוו	ding Prystolant: The lar n. After this certificate has funeral director, page 2		25. Was case referred to medical					performed	l? death?	2 No
>	rnysicia this cert al direct	To Be	examiner?	Hospital:	2 ER/Outpatient	Othor	26. Place of Death 1: 4 □ Nursing Hore		e 6 ⊡Other (Spe	cify)
	ng Mfle Ine	tion:	27. Manner of Death 1 ■ Natural 5 □ Pendin 2 □ Accident investig		Year) 28b. Time of Injury	28c. Injury Work? M 1 1 Ye	at 2 es 2 □ No	8d. Describe how in	njury occurred	
2	lo the Hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could r 4 Homicide determ	ot be 280 Place of Injury	/ - At home, farm, stre (Specify)			8f. Location (Stree City or Town, S	t and Number or Ru tate)	ıral Route Number,
ָ ב	pspital of hours a ineral D y filled i		29a. Certifier 1 Certifyin	g Physician: To the best of	my knowledge, death	occurred at the time	e, date and place, a	and due to the caus	e(s) and manner as	s stated.
44	vithin 24 hours a To the Funeral Completely filled	Medical	(Check only one) 2 Medical 29b. Signature and title of certifier	Examiner: On the basis of e and manner state	xamination and/or inv	estigation, in my op	inion, death occurre	ed at the time, date	and place, and due	to the cause(s)
,	N L	-	a M	at C.S.	of MD	29c. License	number 1052 950	0 290.	entarh	- 22, 2008
7	1		30. Name and address of person	who completed cause of dea	th (Item 23a) (Type P	Cint) of E	In P	audu/1	Story	22,2008 MJ
	Stat		31. Date filed (Month, Day, Year) SEP 3 0 20	32. Registrar	s Signature	·	Wy. H	w ACL	3 lowy	1770.
	Registra	ir	oero u Zl	08 Jenes .	A. Aparel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ivial yland	Death		g. No. 2008	3 3 1 2	205				
	Physicia	an	1. Decedent's Name (First, Middle, Last FLORENCE)	WEINE	R		2. Date of Death SEPTEMBE	R 26 2008	3. Time of 12:25	Death A M		
-	/Medic Examin		4a. Facility Name (If not institution, give		WEINE		Location of Death		4c. County of De	ath			
4			SPRINGHOUSE ASS 5. Social Security Number 6. Se	T	act hirthday)	If Under 1 Year	PIKESVIL If Under 24 Hrs.	8. Date of Birth		IMORE	r Foreign		
	Funeral Director		214-03-0663	х Дм 2 Д F 93	Yrs.	Months Days	Hours Min.	09/01/19	915	rthplace (State o			
	/land low		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside Cit			
	Ba-f sh	ctor	FL PALM BEA	СН	V 18	4 4 10	BOCA	RATON		1 □ Yes	2 X No		
	with th	by Funeral Director	10e. Street and Number 2000 N. OCEAN BLVD	#706		10f. Zip Code	3431	10	og. Citizen of What C USA	ountry?			
	r death	nnera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)					
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, I'm Medical Evantinar must be indiffied at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐Yes 2 ሺ No If Yes, Give Year or Dates:		I∐Yes 2∭No	Specify:		Specify:	WHITE			
15-0	"natur	Completed	15. Decedent's Ede (Specify only highest grad	ication le completed)	(Give	dent's Usual Occup kind of work done OO NOT use retired	during most of work	ing 1	16b. Kind of Busines	s/Industry			
212	d withir giene. er than	omo;	Elementary/Secondary (0-12)	College (1-4or 5+)	me. t	HOMEMAK	,	OWN HOME					
and	be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last) BENJAMIN	ZAPOI	_ I T Z			e (First, Middle, M DSE		CNOWN			
aryl	should and Me s mark umatic	우	19a. Informant's Name/Relationship (7			ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State	Zip Code)			
e, Z	is 1 and 2 is 1 Health a item 27 is other train		RHONA WEINER/DAUGH					-	RSTOWN, MI				
mor	Pages 1 ment of H ant: If ite ury or of		20a. Method of Disposition 1	Removal from State	REI T	sition (Name of natory or other place FILOH CON	BALTIMORE, MD						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Marical Evantment that Lauralibed at once.		21. Signature of Funeral Service Licens		22	Name and Addre			SON & BRO				
			23a. Part1. Enter the disease, or comp	lications that caused the death	n. Do not ent					Approximate Interval Bet	e ween		
	Physician /Medical	8 17	Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCO		IC CARD	TOVASC	MLAR DI	ECRAJE	Onset and I	Death		
	Examiner			Due to (or as a conseque.	uence of):								
	ted trait	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ierice of j:								
), (A)	rificate be executed ng physician and as the burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):								
68760,	icate be physici	dical		d									
Вох		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		∃ Ectopic pregnanc	.v		23d. Date of o				
P.O. B	Physician: The law requires that the death cer this certificate has been signed by the attendir ral director, page 2 should be detached for use	ysicia	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown		Other (specify)		·	Month	Day	Year		
	ss that I gned by se detac	by Ph	Part II. Other significant conditions co	entributing to death but not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	pacco use contribute				
ord	w require s been si should b								s 2 No 3		Unknown		
Division of Vital Records,	Fhe law te has l age 2 s	Completed		<u></u>				24a. Was ar autops perform	y prior t				
/ital	cian; 'ertifica ector, p	Be C	25. Was case referred to medical examiner?	U2-I				1 ☐ Yes 2 th (Check only one			JED		
of	y Physical direction	n: To	1 ☐ Yes 2 🛣 No 27. Mapner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o		4 LI Nursing n		ence 6 Dother (S	pecifyLTVTN	á –		
sion	tending eath. or: Afte the fun	catio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	Injury	M 1 □	k? Yes 2□No						
Divi	I or At after d Direct d in by	Certification: To	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (St. City or Town	reet and Number or n, State)	Rural Houte Nun	iber,		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Ph	/sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the corred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s	s)		
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens	se number	25	9d. Date signed (Mo	nth, Day, Year)			
			KIU har son	MD	00=) /T :	Doc Dates	1931	7	7/2	6/08			
	24		30 Name and address of person who de	completed cause of death (Item	1 23a) (Type	WARRY (AKE DR	BALTE	IMORE 1	1D 21	209		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 3 0 2	32. Régistrar's Signa	ture	book		,					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Fleatth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** HAROLD AVRICK 6:30 A^M SEPT 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FENWICK LANDING SENIOR CNTR. CHARLES WALDORF 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☑ M 2 □ F Director 107-07-4257 91 JUL.14,1917 NEW YORK Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 🏖 🖳 No Director CHARLES MD WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 UNIVERSITY DRIVE U. S. A. 20601 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2√ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR DRAFTSMAN U. S. NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked SAMUEL AVRICK MARY ROTHENBERG ည 19a. Informant's Name/Relationship (Trope Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY ELLEN CROTTERS 15275 DEBORAH DR. HUGHESVILLE, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition SEPTEMBER permit. Pages Department of Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY MEM.GRDNS. 27,2008 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service License Youn Bat & M00641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the s 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed?
Yes 21 No certificate has birector, page 2 s has To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the f 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 h one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0033426 SEPTEMBER 23, 2008

DHMH 17 Rev 1/2001

0

Registrar

State

LA GRANGE AVE. LA PLATA, MD 20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

732. Registrar's Signature

111

LARRY JENKINS

SEP 3 0 2008

31. Date filed (Month, Day, Year)

31. Date filed (Month, Day, Year) SEP 1 7 2008 State Registrar DHMH 17 Rev 1/2001

Zabiullah Ali, M.D.

32. Registrar's Signatur

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

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State of Maryland / Department of Health and Mental Hygiene

31208

Physician /Medical Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examiner must be notified at agine.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	Registrar					Cert	ificat	e or l	Jeatn		Reg. No.					
	1. Decedent's Name	e (First, Midd	lle, Last)				2. Date of Death Day 3							Year	3. Ti	me of Death
in al	Helen Louis	e Brunngr	aber								Septemb	er .	13	203	10	45 AM
er	4a. Facility Name (i		on, give street and nu lospital	umber)				Town, or	Location	of Death			lc. Count Vashing	y of Death gton		
	5. Social Security N		6. Sex	7. Age (Ir	yrs. last birt		day) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year)							9. Birthplace (State or Foreign Country)		
	213-18-9779 Usual Residence of		1 □ M 2 🖾 F		86	Yrs.	MONTHS	Days	Hours		Decembe	er 24,	1921	Hagei	rstowr	n, Maryland
1	10a. State	10b. County	/	10	c. City, Town	or Loca	ation								10d. Ins	ide City Limits
Be Completed by Funeral Director	MD	Washin	igton	j	Hagerstov	vn									1 []Yes 2∭ No
)ire	10e. Street and Nu	mber					10f. Zip	Code				10g. (Citizen of	What Cou	intry?	
<u>a</u>	18901 Rolli	ng Road							21742				U.S	.A.		
ner	11. Marital Status		12. Was Dec Armed F													ian,
교	1 Never Marr	ied 2 ☐ Mai		2 No	lo											
b	3√ Widowed	4 Divorced	d Year or E	Dates:	1 ☐ Yes 2 ☑ No Specify: Specify:									iy:	White	
etec	(Spec	15. Deceder	nt's Education est grade completed)	16a.	Decede	ent's Usu	al Occup	ation during mos	t of work	ina	16b.	Kind of E	Business/Ir	ndustry	
nple	Elementary/Seco		College ((1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)									d Blast	ino	
S			2			Executive Secretary Famin									-	
To Be	17. Father's Name Harold Robe				18. Mother's Name (First, Middle, Maiden Surmame) Anna Velita Snyder Paxson									me)		
-	19a. Informant's N	ame/Relation:	ship (Type. Print)		19b.	Mailing	Address	s (Street	and Numb	er or Rur	al Route Num	ber, City	y or Town	n, State, Zi	ip Code,)
	Robin L. Dea				1	9216	Olde V	Waterfo	ord Road	đ	Hager	stown	1	MD	217	42
	20a. Method of Dis			2	20b. Place of cemeter	Disposi	tion (Na	me of	e) !	[Date	20c.	Location	- City or T	own, St	ate
	1 ☐ Burial 2 2 4 ☐ Donation		3 ☐ Removal from Specify)	State					t t	09/16	/2008	Sn	nithsbu	ırg, MD	2178	33
	21. Signature of Fu				Simulation	22. Name and Address of Facility										
		,	1x Li			Г	gerstown	, Mary	land 21742							
1	23a, Part 1, Enter J	ne disease.	or complications that	caused the	death. Do r	1									Appro	oximate
	shock, or hea		r complications that t only one cause on	each line.								,				al Between t and Death
	disease or condition resulting in death)	on	-a. ACU			ESPIRATORY INSUFFICIENCY										AYS
	, and a second		Due to	(or as a co	nsequence	uence of):										1==1
<u>.</u>	Sequentially list co	nditions,	b. Pue to	17 P. C	nsequence of		100	ARY	O'	750	4				1 4	JULK
nju Bij	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	riying iniury	₹ Due to	(01 as a 00	insequence (٠١).										
xan	that initiated events resulting in death)	s Last	c	o (or as a co	nsequence o	of):								-		
a! E				(,										
n/Medical Examiner			d													
/Me	IF FEMALE:		23c. If yes, ou	utcome of p	regnancy								534 D	ate of deli	verv	
Sian	23b. Was deceden in the past 12	months?	1 Live		Fetal death		Ectopic p	pregnanc	у					fonth	Day	Year
ysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	⊿No	9 □ Unk			<u> </u>	2010/ (3)									
ᆸ	Part II. Other signi	ficant condit	lons contributing to	death but no	ot resulting in	the unc	derlying	cause give	en in Part I		23e. Did	tobacc	o use cor	ntribute to	the cau	se of death?
Completed by Physicia	CONGE	TIVE	HEART F	ALUR	E, C	HRI	DNIC	01	5TR	JUTIV	E 10]Yes	2 🗌 No	3 Pro	obably	4 Onknown
plet	PULMON	DRY.	NIGATE	ACU	TE R	GNA	12/5	ALL	RE		24a. Wa	s an opsy	24b	. Were aut	topsy fir	idings available
E O	C- 10-10	ny Av	De Marie	11550	TE .	Na	OFT	c /	101	2/5	per	formed'	Nio	death? 1 ☐ Yes		
	25. Was case refer	red to medica	al	10 0/70	0, 1	01/7	SUI		26. Place	e of Deat	th (Check only		110	1 1 100		
0 0	examiner? 1 ☐ Yes 2 ☑	No	Hospital:	Inpatient	2 ER/Ou	tpatient	3 🗆 D	OA Oth	or.		ome 5 ☐ Re		6 🗆 0	ther (Spec	cify)	
n:T	27. Manner of Deal		28a. Date	e of Injury	28b. 7	Time of		28c. Injur Worl			28d. Describe				,	
atio	1 ☐ Natural 2 ☐ Accident	5 Pendi invest	ng (Mo	nth, Day, Ye	(a) II	njury	М		Yes 2	No						
ifica	3 Suicide	6 Could	minod 286, Plac	At home, fai	rm, stree	et, factor	y, office			28f. Location	(Street	and Num	nber or Ru	ral Rout	e Number,	
ert	4 Homicide	20.011	Specify)						City or T	own, St	ale/					
Medical Certification: To Be	29a. Certifier (Check only one)	amination an	e, death	occurred	d at the tin	me, date a	nd place ath occur	, and due to the	ne cause e, date a	e(s) and r and place	manner as e, and due	stated. to the c	ause(s)			
Med	29b. Signature and	I title of certific		nner stated		29c. License number 29d. Date signed (Month, Day, Ye					/ear)					
	Sold Signature and	1 T	(0 11	1				A > iA					,		•	
" and to produce of								D38892 9/13/08								
	30. Name and add	ress of person	n who completed cau	use of death	(Item 23a)	(Type, P	rint)	3011	16	130)	02		1246	ER	MONN,
	PATEL	A FO	* NYUM)FC	Distrov's	Signature	_///	101	70	10092	CAY	7/305	(4)		MID	ي کي	1742
te ar	31. Date filed (Mor		8 2008 32.	gistrars	Signature			*								

State Registra

			State of Maryland / Depa		•	•	
				tificate of Death	Reg.	NG UU8 312U9	
Physi /Med			1. Decedent's Name (First, Middle, Last) Carole Burrington		9 1	Day Year 9 M	
	Examin	er	4a. Facility Name (If not institution, give street and number) Longview Nursing Home	Manches Ter	m)	4c. County of Death	
	Funeral Director					ar) 9. Birthplace (State or Foreign Country) 1930 Minnesota	
Maryland Z1Z13-UU36	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc MD Carroll Mancheste			10d. Inside City Limits 12€ es 2 □ No	
	with the lag or 28a-	Director	10e. Street and Number 3332 Main St.	10f. Zip Code 21102	_	Citizen of What Country?	
		by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	las Decedent of Hispanic Orig Yes, specify Cuban, Mexican, ☐ Yes → No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	within 72 hours after ane. than "natural", or ite ne Medical Exprime	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give I	ent's Usual Occupation and of work done during most O NOT use retired)	of working 16b	. Kind of Business/Industry	
	e filed with Il Hygiane other tha vent, the	Be Com	17. Father's Name (First, Middle, Last)	Clerk 18. Mother	s Name (First, Middle, Maid	Government Jen Sumame)	
	ould by Menta arked attic ev	To E	Ernest Harold Hedean My		le Aarstead		
	id 2 sh ith and ith and 27 is m traum		19a. Informant's Name/Relationship (Type, Print) Rebecca Strong / Daughter 2900	Address (Street and Number	or Rural Route Number, Cit lanchester Mi	ty or Town, State, Zip Code) 2110 2	
e,	of Heel		20a. Method of Disposition 20b. Place of Dispos	A STATE OF THE PARTY OF THE PAR		. Location - City or Town, State	
E III	t. Page tment o tant: If tjury or		1 Burial 2 Scremation 3 Removal from State 4 Donation 5 Other (Specify) Hellinger Crematory 9-18-08 Mt. Holly Springs, PA				
Dalt	Depa Impo any ir		21. Signature of Poneral Service Licensee 22. Name and Address of Facility Witzel Funival Home 549 Caviliste St., Hanover, Ph 17331				
ords, F.O. Box 68/80,	ysician end yakidical was harial-transit	cal Examiner	23 ant 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Onse				
	death certifica e attending ph id for use as th	hysician/Medic		1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year	
	in a nospiral or Australia. Within 24 hours after deeth. To the Funeret Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detailed.	Certification; To Be Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacc	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ∜No 3 ☐ Probably 4 ☐ Unknown	
					24a. Was an autopsy performed		
<u> </u>			25. Was case referred to medical examiner? 1 Yes 20 No. Hospital:				
5 8			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. 1		42 Nursing Home 5 Hesidence 6 Other (Specify)		
2			1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	0		
SIN			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, farm, stre building, etc. (Specify)	factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ne Hospi 24 hour ne Funer detely fill	Medical	29a. Certifier (Check out one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	withir Comp	Me	29b. Signature and title of certifier Why W Mullet	29c. License number	29d. Q	Date signed (Month, Day, Year)	
1	7 P		30. Name and ress of person who completed cause of death (Item 23a) (Type, F		t. Manc	hester modulor	
	Sta Begistr		31. Date filed (Month, Day, Year) SEP 1 7 2008	ctory Street	1,10,000	TO TO VIDALOR	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 3_ Sept. 1 15:50 ໝ^M Margaret Martin Barnes 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Golden Crest Assisted Living Carroll Hampstead 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Months Days Hours 213-05-3894 1 □ M 2 🔀 F 8/31/1917 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD. Baltimore Upperco 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5310 Emory Road 21155 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specifywhite 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 5 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles R. Tawney Mary Lucinda Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Barnes 1005 Terrace Ct., son Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trenton Cemetery 9/18/2008 Upperco, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Eline Funeral Home demme Hampstead, Md. 934 S. Main St., 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mastatie Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mon Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 Tho 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 ⊡No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and Injury or other traumatic event, the Wedfral Eventuer out by nonce.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

2

the Maryland

Exami sician and burial-trans attending physician for use as the buria Physician/Medical this certificate has been signed by the al director, page 2 should be detached Completed by Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 0

State Registrar

and manner stated 29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28a. Date of Injury (Month, Day, Year)

Registrar's Signature

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Medical

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** September 14, Calvin R. Burke 2008 1:00 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ♣M 2 ☐ F 579-26-4290 83 Nov. 1924 Washington, 6, Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location show 10a State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be multiled at 1 ☐ Yes 2 ☐ No Director Silver Spring Maryland Montgomery the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15101 Interlachen Drive, #118 20906 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces:
1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1943-46 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7. I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 should be flied with and Mental Hygier 7 is marked other the Civil Engineer Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence R. Burke Edith R. Boyer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun Carolyn B. Filano/Daughter 16105 Emory Lane, Rockville, MD 20853 altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 19, Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2008 Silver Spring, Maryland 21. Signature of Furjeral Service Lice of 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Mec 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Fibrillation, 1 Yes 2 No 3 Probably 4 Unknown Completed been gallstone 24b. Were autopsy findings available prior to completion of cause of death? Pancrentitis 24a. Was an autopsy performe 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation after death.

I Director: Af din by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Obandapod Court, Olvey, Maryland 20832 20+1 Name and address of person who completed cause of Math (Item 23a) (Type, Print) Woodeenod HATHUR F. VE Date filed (Month, Day, Year) State SEP 16 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#23a(a)perMD, 9-16-08, BWW, Mood Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** DEMBER 12 2008 0212 AM Elihu Aaron Boldt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, Year) July15,1931 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** 1 √ M 2 □ F Months Days Hours New Jersey 139-24-0285 77 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show inportant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, its Medical Exapinat russ be nutified at any injury or other traumatic event, its Medical Exapinat russ be nutified at any once. 1 X Yes 2 □ No Prince George's Director Maryland Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20770 10 Lakeside Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or-5+) Elementary/Secondary (0-12) Astro Physicist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joel Boldt Yetta Edith Miller ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Lakeside Drive Greenbelt, Maryland 20770 19a. Informant's Name/Relationship *(Type. Print)* Yvette Boldt **-**wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Shaarey Tefiloh Cemetery 9/17/2008 Perth Amboy, N.J. 4 Donation 5 Dother (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service License Morald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ventricular Fibrillation Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine siclan and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 24 hours after death.

• Funeral Director: After this certificate has been signed by the attending physiclan letely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ZNo 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Funer completely fil and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 12

State Registrar

DHMH 17 Rev 1/2001

SEP

IFIE 31. Date filed (Month, Day, Yelar)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. V.

32 Registrar's Signature

Jingo

1 6 2008

Certificate of Death

2. Date of Death

Physician /Medical Examiner

Seth BENJAMIN 4a. Facility Name (If not institution, give street and number)

1. Decedent's Name (First Middle Last)

4b. City, Town, or Location of Death

3. Time of Death Sept. 13, 2008 10:27 PM

Shady Grove Adventist Hospital 6. Sex

1 M M 2 □ F

Rockville

4c. County of Death Montgomery

Funeral Director

d other than "natural", or Items 23a or 28a-f show event, the Madical Exerciper must be notified at

Department of Health Important: If Item 27 any Injury or other trong once.

Physician

/Medical

Examiner

burial-trar

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

Funeral

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Completed

Be

2

Examine

Physician/Medical

Completed by

Certification: To Be

Medical

Pages 1 and 2 should be filed within 72 hours after death with

Saltimore, Maryland 21215-0036

Usual Residence of Decedent 10a. State 10b. County

10c. City, Town or Location

7. Age (In yrs. last birthday)

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | July 4, 1959 9. Birthplace (State or Foreign New York

5. Social Security Number

119-52-8995

10d. Inside City Limits 1 □Yes 2 No

Maryland

Montgomery

Germantown 10f. Zip Code

10g. Citizen of What Country?

10e. Street and Number

20914 Mountain Lake Terrace

20874

United States

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race - American Indian, Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

Jack Benjamin

18. Mother's Name (First, Middle, Maiden Surname) Audrey Garber

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a, Informant's Name/Relationship (Type, Print) Audrey Benjamin, Mother

10314 10 Boone Street, Staten Island, NY

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Beth Israel Cemetery

20c. Location - City or Town, State 09/16/08

Woodbridge, NJ

21. Signature of Pyneral Service Licensee 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Respiratory Failure Due to (or as a consequence of):

Pneumonia

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure, Diabetes Mellitus, Morbid Obesity,

Cellulitis

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown

autopsy performed? Yes 2 No 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

3 Suicide

25. Was case referred to medical 1 Yes 2 X No

29b. Signature and title of certifier

27. Manner of Death 1 X Natural 2 Accident

5 Pending investigation 6 Could not be

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

Hospital:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier (Check only one)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

67593

29c. License number

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year) Soptember 13 2008

Zewlie, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wubnew Zewdie, M.D., 9901 Medical Center Drive, Rockville, MD

State Registrar

31. Date filed (Month, Day, Year) 2008



DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 🗅 Certificate of Death 2. Date of Death 3. Time of Death **Physician** Month Day James Frederick Barrett September 14, 2008 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sandy Spring
If Under 1 Year | If Under 24 Hrs. Brooke Grove Rehabilitation and Norsing Center Montgonery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 8. Date of Birth (Month, Day, 1**™** M 2□ F Months Days Hours Min. 363-16-2183 88 July 27, **Director** 1920 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination until to multify of all Director 1 ☐ Yes 2 XNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1609 Chester Mill Road 20906 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ★ Yes 2 □ No 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1947-63 1 ☐Yes 2 No þ Specify. Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Lee Barrett Ruth Pierson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Marian E. Barrett/Wife 1609 Chester Mill Road, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of It Important: If Ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Dec. 12 Arlington National 4 □ Donation 5 □ Other (Specify) 2008 Cemetery 2008 Arlington
22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Arlington, Virginia 21. Signature of Funeral Service Linensee pu 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician multilobar phecimonia duys disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by acite. an-chronic 1 Yes 2 No 3 Probably 4 Unknown page 2 should bladder cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Vital 1 ☐Yes 2 ☐ No 1 □Yes or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eted cause of death (Item 23a) (Type, Print)
M.D. (9100 Slade School Road Sandy Spring) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

amend line 14 per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 09/12/08 dlwState of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 9 2008 **Physician** Cirnell Brown Jr. 3:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1974 Scott Crossing Way Apt 104 Anne Arundel Annapolis 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Dec 7 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1. M 2 □ F 217-50-9506 62 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be restilled at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1974 Scott Crossing Way Apt 104 21401 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ∐Yes 2 [A]No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify. Specify: Hlac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) 12th 4vrs Custodian Community College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cirnell Brown Sr. Mary Wills ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mildred Curtis(Sister) 4406 Bishopmill Dr. Upper Marlhoro, Md.20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory 9-15-08 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) P.A. 21401 21. Signature of Funeral Service Licensee Ambleme & Bades of Scills ons Mortuary, 821 West St. Annapolis, Md. 14.1 Resemco483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) Minu e **Physician** auc YOU. /Medical Que to (or as a consequence of): ovascular Examiner enosch Sequentially list conditions, in a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marfier|stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) State SEP 1 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0245 Am ARNES EPTEMBER 13 2008 ANNIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES AUREI HOSPITAL KEGIONAL 8. Date of Birth (Month, Day, Year) 11/16/17 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🔀 F Months Days Hours 90 Tazwell TN 401-16-1603 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medicol Eval: incr. ust by notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Virginia Beach 1 Yes 2 No VA. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23464 USA 6440 Duquesne Place Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, GiveX Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Be Completed by 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Coleman Lillie Greer Roy ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9512 Woodstock Court Silver Spring,MD 20910 Lynn Barnes Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9/15/08 Glen Burnie,MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Hardesty Funeral Home P.A. 851 Annapolis Taty 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KESPIRATORY Physician resulting in death) /Medical Due to (or as a consequence of) Examiner P Sequentially list conditions, if any, leading to in in south cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed 1POX12 and -trar that initiated events resulting in death) Last ng physician ar as the burial-t Box 68760, ANEMIA Physician/Medical been signed by the attending should be detached for use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 0 ☐Yes 2 No 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division (Month, Day, Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SEPTEMBER 13 2008 MD 65329 30. Name and address of person who completed cau of death (Item 23a) (Type, Print)

State

REGIONAL AUREL 31. Date filed (Month, Day, Year) 2008 15

HOSPITAL @ 7800 VAN DUSEN ROND. LAUREL MD 20708

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day September 13 2008 0250 A M **Physician** Kenneth Leroy Barnes /Medical 4b. City, Town, or Logation of Death County of Death 4a. Facility Name (If not institution, give street and numb Examiner Dorches ambride GENERAL If Under 1 Year If Under 24 His. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 ☐ F Director 219-07-7887 90 July 27, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge 1 ☐ Yes 2 🗓 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 5314 Suburban Drive 21613 USA by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner once. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify. Specify: white 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Ellis Barnes ျ Edith May Insley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Barnes son 5312 Suburban Drive, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bucktown Churchyard 9/17/08 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatur A Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Cardiovascula Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ e ment à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 2 No 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: illed in by the funera 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9-13-08 D47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO10 2-16/3 THANWY 03 CAMBRIDGE 31. Date filed (Month istrar's Signature State 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	1 - State Registrar			Cert	ificate of I	Death		Reg. No.	2008	31218
Discription		1. Decedent's Name (First, Middle, La	st)					2. Date of D		Year	3. Time of Death
Physicia /Medic	_	Donald Ellis	on Courtne	ey				09	21	2008	0159 M
Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death	1	4c. C	County of Death	
		MEMORIAL HOSPITA				CUMBERI				ALLEGAN	Y
Funeral		Social Security Number 6. S	Sex 7. Age 1 127 M 2 □ F	e (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth ay, <i>Year)</i>	9. Birthp Coun	lace (State or Foreign
Director		235-30-2089 Usual Residence of Decedent		81	115.			March	15,19	27 Keys	ser, WV
and w	ŀ	10a. State 10b. County		10c. City, To	wn or Loca	ation				1	0d. Inside City Limits
Aaryl f sho	5	MD Alle		D1 d							1 ☐ Yes 2 📉 No
the last	Director	10e. Street and Number	gany	Rawli	ings	10f. Zip Code			10a. Citiza	en of What Coun	itry?
with 3a or t be		19423 Tom's Ho	llow Pond	C LI		215	E 7				,
Jeath	Funeral	11. Maritai Status	12. Was Decedent E		13. W		D / ispanic Origin? (S an, Mexican, Puerl	pecify Yes or N	0- 1-	USA 4. Race - Americ	an Indian,
r iter	교	1 ☐ Never Married 2X Married	Armed Forces? 1 MYes 2 □ N If Yes, Give	No				o Rican, etc.)		Black, White,	etc.
al", o	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	WW II	1	□Yes 2M∏No	Specify:			Specify: Wh	ite
72 hc natui	Completed	15. Decedent's E (Specify only highest gra	ducation			ent's Usual Occup	ation during most of wor	rkina	16b. Kin	d of Business/Inc	Justry
ithin ne.	ם	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. De	O NOT use retired	d)	ning			
ed w ygier rer th	S	5			Se1	f employ				Barber	Shop
tal H d out	Be	17. Father's Name (First, Middle, Last	,				18. Mother's Nar			,	
Men Men arke	ရ	Ellison Courtne						la Kuyk			
2 sh and Is m		19a. Informant's Name/Relationship	Type. Print)	19	9b. Mailing	Address (Street	and Number or Ru	ıral Route Num	ber, City or	Town, State, Zip	Code)
l and lealth im 27 ther t		Helen C. Courtney 20a. Method of Disposition	/Wife	20h Blood	P.O.	Box 290	Rawling	s, MD_	2155		
or of let		1 X Burial 2 ☐ Cremation 3 ☐		ceme	tery, crem	atory or other plac	Seni	25	20C. LOC	cation - City or To	wn, State
t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Special		Queen		oint Ceme	etery 20	008		yser, WV	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inipportant: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	hsee /_ 77	1	22.	Name and Addre		Smith F			706
		23a. Part1. Enter the disease, or com	o Fuce	the death D			ain Stree		yser,	WV 26	726
		shock, or heart failure. List only	one cause on each lin	ne.	o not ente	the mode or dyli	ig, such as cardiae	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Pulmona: Due to (or as a	rv eder	na						
Examiner			Due to (or as a	a consequenc	e of):						
	<u>-</u>	Sequentially list conditions, if any leading to immediate	b Due to (or as a	a consequenc	e of):						
Jx · He · Jisi	듵	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,						
al-tra	Examiner	resulting in death) Last	C. Due to (or as a	a consequenc	e of):						
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			-d								
Sertificat ding phy se as th	Medical		-4								
leath cer attendin	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		Ab 0 🗆				2:	3d. Date of delive	ery
deat death	Sicial	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at			Ectopic pregnancy Other <i>(specify)</i>	<i>'</i>			Month	Day Year
res that the de signed by the s	Physician	9 ☐ Unknown	9 Olikilowii								
es tha	by	Part II. Other significant conditions	contributing to death bu	ut not resulting	j in the und	derlying cause giv	en in Part i.	23e. Dio	I tobacco us	e contribute to the	ne cause of death?
w requires been si should?								19	Yes 2]No 3 ☐ Prob	pably 4 □Unknown
law r as be	ble							24a. Wa	s an opsy	24b. Were auto	psy findings available mpletion of cause of
	Completed							per	formed? 2 X No	death?	2□ No
sician: The certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)		
Physician: The law rthis certificate has trail director, page 2 s	၉	1 Yes 2 No	Hospital: 1 Inpatie			3□ DOA Oth	4 Li Nursing F	lome 5□Re	sidence 6	☐Other (Specif	у)
ding Ph h. After thi funeral	ii o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b y Year)	Time of Injury	28c. Injur Wor		28d. Describe	how injury	occurred	
tend eath. tor: /	cati	2 Accident investigatio 3 Suicide 6 Could not b					Yes 2 □ No				
or At fter d Direc in by	Certification:	4 ☐ Homicide determined		ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location City or T	(Street and own, State)	d Number or Rura	l Route Number,
pltai ours a eral I	- 1	29a. Certifier Certifying P	hysician: To the best of	of my knowled	lae dooth	occurred at the 45	mo data and als-	and due to the	0.001105/-1	and manner	tated
Hos 24 ho Fun stely	edical	(Check only one)	miner: On the basis of and manner sta	t examination	and/or inv	estigation, in my o	me, date and place opinion, death occ	e, and due to thurred at the time	e, date and	and manner as si place, and due to	tated. the cause(s)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Mec	29b. Signature and title of certifier	and manner sta	atou.		29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
F 3 F ŏ		(,)									
$ \mathcal{Q} $	-	30. Name and address of person who	completed cause of di	eath (Item 22a	a) (Tune D	D2337	T		septe	mber 21,	, 2006
		Qamar Zaman, M.		ton Dr		,	Land, MD	21502)		
Sta		D. D. W. L. (1. D. A.)		ar's Signature		elle)					
Registr	ar	9 mil - V L		20	The same						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** GLEN HAYES М COLBERT SEPTEMBER 11. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVERSPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day) **Funeral** Year. Days Min. 214-36-3657 1 M 2 □ F 04-24-1940 WASHINGTON, DC **Director** 68 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Examirer must be redilied at 1 Yes 2 □ No UPPER MARLBORO PRINCE GEORGE Director MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A. 20772 9529 CASTLE DR Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. filed within 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: à 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT BULDING SUPERVISOR Pages 1 and 2 should be filed wit timent of Health and Mental Hygien tant: If item 27 Is marked other th jury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARTHA G. SPENCER ERNEST HAYES COLBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5807 ROBIN LANE CAMPSPRINGS, MD 20746 SHARON ALSTON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY09-17-2008 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensed 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ABDOMINAL CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASCITES Sequentially list conditions, any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi PANCREATIC CANCER Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a P.O. 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CACHEXIA certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 2 2140 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: al or Attending F after death. I Director; After d in by the funera Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier D0065485 panich, RSM, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 MD 1500 FOREST GLEN ROAD SILVERSPRING, MD 20910 BARBARA SUPANICH, 31. Date filed (Month, Day, Year) 32. Registrar's Signature 7 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** EMMETT CARROLL SEPTEMBER 14, 2008 8:39 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4517 KINMOUNT RD PRINCE GEORGE LANHAM If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1**★** M 2□ F 223-36-2086 Director 78 05-30-1930 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD PRINCE GEORGE LANHAM 1\ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 4517 KINMOUNT RD U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

12 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married "natural", or If Yes, Give Year or Dates KOREAN 1 ☐ Yes 2 No Specify. Specify: BLACK 2 3 ₩ Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 | (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th 12 should be filed whand Mental Hygien 7 is marked other the BRICK LAYER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EMMETT L. CARROLL ELEH HENDRICK or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al
Important: If Item 27 is
any injury or other trau DORIS PATRICK/SISTER-IN-LAW 4517 KINMOUNT RD LANHAM, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09-20-2008 MT. OLIVET CEMETERY WASHINGTON, DC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner **HYPERTENSION** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examiner certificate be executed DIABETES MELLITUS TYPE II and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ē in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe

1 Yes 2 No 3 Probably 4 HUnknown

24a. Was an autopsy perform rmeg? 2 No 1∐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【★No

25. Was case referred to medical examiner?
1 Yes 2 No

27. Manner of Death 5 ☐ Pending investigation 2 Accident 3☐ Suicide

6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 ☐ Homicide

29a. Certifier

29c. License number MD# 34028

29d. Date signed (Month, Day, Year) SEPTEMBER 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL P. VILLAROMAN, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

State Registrar

Completed

Be

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Certification:

Medical

certificate

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After

I Director: d in by the

death

after

To the Hospital within 24 hours a To the Funeral C completely filled

31. Date filed (Month, Day, Year) SEP 1 7 2008



10

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Records,

or Vital Physician:

Division Hospital or Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	of Maryland / Depa <i>Ce</i>	artment of Healt <i>rtificate of Dea</i>	h and Mental Hyg th	giene 2008	31221
	Physic		1. Decedent's Name (First, Middle, Last) Robert Bobby Cunn:			2. Date of Dea		3. Time of Death 8 9:50 AMM
	/Medi Exami		4a. Facility Name (If not institution, give street and Southern Maryland	number) Hospital	4b City, Town, or Locati		4c. County of Death Prince G	
	Funeral Director		5. Social Security Number 6. Sex 12 M 2	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year If Un Months Days Hou	der 24 Hrs. 8. Date of Birth rs Min. 0 //14	9. Birth Cou 1946 Wash	place (State or Foreign ntry) ington, DC
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince Georg	ges District	ocation t Heights			10d. Inside City Limits
	3a or 28	Funeral Director	10e. Street and Number 1839 Addison Road		10f. Zio Code 20747	1	og Citizen of What Cou USA	ntry?
960	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evon increment to another traumatic at a context of the medical Evon increments.	É	1 ☐ Never Married 2 ☐ Married 14☐ Yes,	es 2 □No l	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 □Yes 2 No Spec	Origin? (Specify Yes or Noican, Puerto Rican, etc.)	14. Race - Ameri Black, White, Specify: B1	
21215-0036	d within 72 ho giene. ir than "natui	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+) 16a. Dece (Give Cont	dent's Usual Occupation kind of work done during r DO NOT use retired) CRACTOR	nost of working	16b. Kind of Business/In	,
land	ld be filed fental Hy ked othe itc event,	To Be C	17. Father's Name (First, Middle, Last) Walter Cunningham			other's Name (First, Middle, I		
Maryland	1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than other traumatic event, the Menter traumatic event, the Me	-	19a Informant's Name/Relationship (Type. Brint). Sara Cunningham/Wi	fe 19b. Mailii 1839	ng Address (Street and Nu Addison F	mber or Rural Route Number	r, City or Town, State, Zi, District	ocode) 20747 Heights MI
altimore,	Pages 1 ar nent of Hear int: If item iry or othe		20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crei Cheltenh	osition (Name of matory or other place) nam Veterar	Date 09/19/08 C	20c. Location - City or To heltenham	
Balti	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Funeral Pervice Licensee		2. Name and Address of Fa	cility 5635 Eads S	t. NE Wasi	20019 nington,DO
	res that the death certificate be executed Signed by the attending physician and be detached for use as the burial-transit Table detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of): to (or as a consequence of):		as cardiac or respiratory arr	est,	Approximate Interval Between Onset and Death
. Box (death certi e attending d for use a	Physician/Me	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
ds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to	o death but not resulting in the u	nderlying cause given in Pa		pacco use contribute to t	
<u>ж</u>	The law requii ate has been s page 2 should	Completed	renal insuffic	iency)	24a. Was a autops perfor	y prior to co	opsy findings available impletion of cause of
Vita	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner? 1 Yes 2 140 Hospital: 1	Hnpatient 2 ☐ ER/Outpatier		ace of Death (Check only on	e)	
ion of	ding After fune	Certification: To	27. Manner of Death 28a. Da	ate of Injury 28b. Time of Injury Injury		28d. Describe ho	ow injury occurred	19)
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Sertific	3 Suicide 6 Could not be determined 28e. Pla	ace of Injury - At home, farm, str ilding, etc. (Specify)	eet, factory, office	28f. Location (Si City or Town	reet and Number or Run n, State)	al Route Number,
	e Hospitt 24 hours e Funera eletely fille	Medical ((Check only 2 Medical Examiner: On the	the best of my knowledge, deat e basis of examination and/or in anner stated.	h occurred at the time, date vestigation, in my opinion,	e and place, and due to the c death occurred at the time, d	ause(s) and manner as ate and place, and due t	stated. o the cause(s)
	Volthir comp	Me	29b. Signature and title of certifier		29c. License numb	1289	9d. Date signed (<i>Month</i> ,	_
A	(3)		30. Name and address of person who completed c	ause of death (Item 23a) (Type,	Print)	inton Mcl	20735	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 1 6: 2008	Registrar's Signature				
DHN	/H 17 Rev 1/2	001	, , , , ,	~ 1				

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Allen Ca		1- For State	ate of Mary		artment of		d Menta	l Hygiene	2	008 312
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Midd			LEN CAUI			2. Date of D	Reg. No. Death Day Year 21, 2008	3. Time of Death 0114 hrs
1.		4a. Facility Name (if not institution 13715 Catoctin Furna		number)		4b. City, Town, or Thurmont	Location of I		4c. County of	
Funeral		Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Yea	r If Under 2	4Hrs. 8. Date of		Birthplace (State or
Director		216-80-4210	1X M 2 F		43 Yrs	Months Day	s Hours	Min	h 9, 1965	Foreign
		Usual Residence of Decedent							, , , , ,	
w any	4	10a. State 10b. County			y, Town or Locati	on				10d. Inside City Limits
yland y-f sho	흱	Maryland Frede	erick	Th	urmont	10f. Zip Code			10g. Citizen of Wha	1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	12 Clarke Avenu	ie			21788	3		U.S.A	
with to mis 23a be not	uneral	11. Marital Status		ecedent Ever in				? (Specify Yes or	No- 14. Race -	- American Indian, Black,
r death or ite	Fun	1 Never Married 2 X M	arried 1 X Yes	Forces?		es, specify Cubar		uerto Rican, etc.)	White	
rs afte ural",	à	Widowed 4 Div	/orced If Yes, Give Yor Dates:	ear 1999	1 16a Deceden	Yes 2 X No t's Usual Occupa		d of work done	Specify: 16b. Kind of Bus	White
72 hou	eted	Elementary/Secondary (0-12)		(1-4 or 5+)	during m	ost of working life	. DO NOT us	e retired)	TOD, TAING OF BUS	micss/modelity
036	Completed	12			Com	ponent 1	Cech		Airpla	ne Parts
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle Lawrence Caudi					18.Mother's I Nancy		e, Maiden Surname)	
212 buld be I Ment mark ic ever		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stree			Number, City or Town	n, State, Zip Code)
MD d 2 sho lth and n 27 is numati		Diana J. Caudi	.11 / Wif							g, MD 21727
ore, sslan of Hea If iter		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal	I .	. Place of Dispos crematory or oth		metery,	Date	20c. Location -	City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donatton 6 Other S	oecity:		sthaven					ck, Maryland
Bal permin Depar Impor	-	21. In nature of Juneral Survice	ronsee	Huk	₹ 23 K	ERT E. D	AILEY	& SON FUREET, THU	JNERAL HOM	IES, P.A. 21788
Physician	T	23a. Part I. Enter the disease, of failure. List only one cause	complications that	caused the deep	h. Do not enter th	ne mode of dying,	such as card	liac or respiratory	arrest, shock, or hea	rt Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease	a. Multiple Ir							Death
-/	-	or condition resulting in death)	Due to (or as	a consequence	of):					
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence	of):					
=	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):					
be executed sician and urial - transit	edical E	UNPENDED	dAMENDED	<u> </u>					-	
		IF FEMALE:	23c. If yes	, outcome of pre	gnancy	-			23d. Date of	delivery
OX 68760 eath certificate I e attending phys	ian/	23b. Was decedent pregnant in the past 12 months?	Live	birth enant at time of c	Janth - H	tal death 3	Ectopic p	regnancy	Month	Day Year
Box 6876 e death certificate the attending phy ed for use as the least	Physician/M	1 Yes 2 No 9 Un	coours I	nown	oti	ner (Specify)				
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	by Pr	Part II. Other significant condit	ions contributing	to death but not	resulting in the u	nderlying cause g	given in Part			oute to the cause of death?
ls, P quires t								1 24a. W	Yes 2 ✔ No 3	Probably 4 Unknown /ere autopsy findings available
cords law requi	Completed							au	itopsy pi	rior to completion of cause of eath?
Vital Recysician: The I		05 M/				00 PI	(5) (1) (6)	1 🗸 Ye		Yes 2 No
/ital	Be	25. Was case referred to medica examiner?	Hospital: 1	Inpatient 2	ER/Outpatient		Othor	neck only one) Jursing Home 5	Residence 6	Other: Scene
of Viring Physical After this	⊢ ⊦	1 ✓ Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time of Ir		ry at Work?	28d. Descri	be how injury occurre	ed
Sion ttendir death. ctor: A	atio	Natural 5 Pend 2 Accident Invest	ding Aug 21	th, Day Year) , 2008	0101 hrs	1`	Yes 2 V N	o Driver au	to fixed object c	ollision
Division of Vital Records, within 24 hours after death. To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should to	Certification:	3 Suicide 6 Coul	d not be 28e. Pla		home, farm, stree	t, factory, office b	uilding, etc.		n (Street and Numbe n, State) octin Furnace Roa	r or Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		4 Homicide	(0,000,1)	Docal Stre						
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		aplin Bra	self 11.	2		O.C.I	M.E.		August 21,	2008
TIVIX		30. Name and address of person	· ·	,	,		-14!	MD 0400:		
CIVI	100	Melissa Brassell, MD 31. Date filed (Month, Dav, Year)	Assistant M	edical Exam		enn Street, B	altimore,	IVID 21201		
Sta Registr		AUG 2 5	2008	Police 1	ture .	Me !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 0.00

			1 - For State Registrar				rtificate of I				Reg. No.	108	3	1223
	Physici	an	1. Decedent's Name (First, Middle, La	st)			-			Date of Dea Month	th	Vear	3. Tir	me of Death
	/Medi		_Joseph Willia						SEP!	TEMBE	ER 22.	200	18 01	:35AM
	Examir	ner	4a. Facility Name (If not institution, giv	e street and number) Medical	Cent	er	4b. City, Town, or		f Death DWSOT		4c. Cour	nty of Dea		ne
	Funeral		Social Security Number 6. 8	ex 7. Age	(In yrs. last		If Under 1 Year Months Days	If Under 2 Hours		Date of Birth	Year)	9. Bi	rthplace (S	tate or Foreign
	Director		220-36-2452 Usual Residence of Decedent	A W ZOF	67	Yrs.						, 194	0 Ma	ryland
	land ow		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Insi	de City Limits
	Mary	ģ	Maryland Balt	imore	Cocke	eysv	ille						1 🗆	Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	10g. Citizen o	f What C	ountry?	
	23a	rail	10205 Sunnylak	e Place, P	Apt0	C	21030			Ţ	J.S.A.			
	er dez items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Vas Decedent of H fYes, specify Cuba	ispanic Orig ın, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)		ace - Am lack, Whi	erican India te, etc.	an,
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Exacting must be reaffed at	by	1 ☐ Never Married 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ☐ N If Yes, Give Year or Dates:	0	1	□Yes 2√2 No	Specify:			Spec	eify: Wh	ite	
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<u>a</u>	Aenta Aenta rked tic ev	To B	James T. Dulan	v				Eliz	zaheti	h Koz	lowsk	ci		
aZ	2 should and Men is marke aumatic	_	19a. Informant's Name/Relationship (1	9b. Mailin	g Address (Street a	and Number	r or Rural Ro	ute Number	r, City or Tow	n, State,	Zip Code)	D 210
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Marie K. Dula	ny/Wife	1	1020	5 Sunny	lake	Place	e,Apt	C,C	lock	eysv.	ille,
Baltimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐	Removal from State	20b. Place ceme	of Dispos etery, crem	sition (Name of natory or other place	e)	Date		20c. Location	n - City or	Town, Sta	te
	t. Pag tmen tant: njury		4 ☐ Donation 5 ☐ Other (Specif	()	Bayv		Cremato				altim			
a n	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licer	see ///		22	Name and Addres	s of Facility	Marzu	ıllo	Funer	al	Chape	el,P.A.
	202 (10)		23a. Part 1. Enter the disease, or com-	argullo	the death D	160	009 Hari	tord	Road.	Balt	imore	, Ma	rylaı	nd21214
L	Division	E 01	shock, or heart failure. List only	one cause on each line	9.				ardiac or res	spiratory arr	est,			l Between and Death
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a			CANCER	₹					ADVA	ANCED
	Examiner			Due to (or as a	consequenc	e oi).								
	p ±	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to lor as a	consequend	e ofy								
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00	ertificate be executed ling physician and e as the burial-transit	Medical		.d										
Š	leath certi attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f <u>pregnancy</u>						23d D	ate of de	livory	
	death	Physician	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2			Ectopic pregnancy Other (specify)					1onth	Day	Year
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5	ding Physician: The lav h. Affer this certificate has funeral director, page 2 !	n: To	27. Manner of Death	28a. Date of Injury	t 2 □ ER/0	. Time of	28c. Injury Work	4 LI Nurs			ence 6 O		ecify)	
5	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day,	Year)	injury		? ′es 2 🗀 No			,,			
2	r Atte er dea recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home,	farm, stre	et, factory, office		28f. L	ocation (Sti	reet and Num	ber or R	ural Route	Number,
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	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of iner: On the basis of and manner state	examination a	ge, death and/or inv	occurred at the timestigation, in my op	ne, date and pinion, death	place, and d occurred at	due to the ca the time, da	ause(s) and r ate and place	nanner a	s stated. e to the cau	ise(s)
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			Day and	ines	ita n	0.0	D414	10		5	ic Ptami	ben !	22 nu	2008
ř	14		30. Name and address of person who o	ompleted cause of dea	ath (Item 23a) (Type, P	rint)				-			
	1 1		JOGINDER, P. MEI 31. Date filed (Month, Day, Year)	HTA, M.D.	764	0 16	SLER DR	IVE	TOWS	ON, ME	RYLA	VD E	1274	
	Stat Registra	~	SEP 3 0 2008	32. Registrar	o orginature	Some								
				The state of the s	54	1000								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 755 000R xedember Bctty L. Dayton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Dorchester General Hospital Cambridge If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Months Days 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours 1 M 2 F 148-18-5835 Director 7/18/1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10h County 10a State show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantinar must be notified at 1 Yes 2 No Director Maryland Dorchester Cambridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21613 Completed by Funeral 224 Meteor Ave, Apt. 102 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Co-Owner Food Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Lauck Fred Lyons ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 224 Meteor Ave, Apt. 102 Fred Dayton / Son 20c. Location - City or Town, State Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 9/24/2008 Mid Shore Cremation Center 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD Signature of Funeral Service Lie 22. Name and Address of Facility Mid Shore Cremation Center 2272 Hudson Rd., Cambridge, MD 21613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) piration **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Dirate Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation 1 □Yes 2 🗆 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Wib MD 300 Byrn Street -

Doc65528

Cambridge

22/08

		Please Type or Print in Black Inc State of Maryland / Depa		-	-
		1 - State Registrar Cer	tificate of Death	Reg.	No.2008 31225
Physici /Medic		1. Decedent's Name (First, Middle, Last) Wyomia Dobbins		2. Date of Death 0 9 1.0 / 2	8 Year 0030 A M
Examir		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery
Funeral Director		5. Social Security Number 5.78 – 5.8 – 4.16.2 6. Sex 1 □ M 2.45 F 6.3 1 □ M 2.45 F 6.3 1 1 □ M 2.45 F 6.3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 0 7/29/I	9. Birthplace (State or Foreign Country) 945 Virginia
Maryland -f show	tor	Usual Residence of Decedent 10a State 10b. County 10b. County Washingto	eation DN		10d. Inside City Limits 1 ☐ Yes 2 █ No
h with the l 23a or 28a st be notif	Funeral Director	10e. Street and Number 3907 20th St. NE	10f. Zip Code 20018-3041		Citizen of What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	þ	4 D Novey Married 2 N Navyied 1 DVes 2 N No	Vas Decedent of Hispanic Origin? (Sp Yes: specify Cuban, Mexican, Puerto ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
within 72 ho giene.	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of work 100 NOT use retired) n Resources Re]	ing	o. Kind of Business/Industry Agency entral Intelligenc
raryrania 2 should be filed and Mental Hyg Is marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last) Bernard Younger	Adela Co		
and 2 sho leatth and m 27 Is me her traums		19a Informant's Name/Relationship (Type. Print) Rice Dobbins/ Husband 3907	g Address (Street and Number or Run 20th St. NE Wa	al Route Number, Ca shingto	ity or Town, State, Zip Code) on , DC 20018-3041
Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ition (Name of latory or other place)		c. Location - City or Town, State adensburg MD
permit. Departr Importa any inju		21. Signature of Funeral Service Licensee Du	Name and Address of Facility Inn&Sons 5635 E	ads St.	NE Washington, DC
∼ Physician		23a. P. 1. Enter the disease, or complications that caused the death. Do not enter prock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	er the mode of dying, such as cardiac	or respiratory arrest	, Approximate Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of):	, ,		
ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c			
BUX 507,000, eath certificate be executed attending physician and for use as the burial-transit	-	d.			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ysician/Medica		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
w requires that the de to be should be detached	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The law rectate has bee page 2 shou	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
sician: certific	Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ Mo Hospital: 1 □ Inpatient 2 □ ER/Outpatient	Othor:	h (Check only one)	ee 6 ☐ Other (Specify)
To the Hospital or Attending Physician: The lywithin 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion: To	27. Manney Death 1 Natural 5 Pending 2 Accident investigation 2 Accident (Month, Day, Year)	T 3 DOA 4 I Nuising Ho	28d. Describe how	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
e Hospita 124 hours e Funera Iletely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.			
To th withir To th comp	Me	29b. Signature and title of certifier , MD	29c. License number 0 0 0 6 6 1 0	0	Date signed (Month, Day, Year)
R(15)		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) TALFMIND (10 A Gu	20903
Sta Regist		31. Date filed (Month, Day, Year) SEP 1 6 2008			()

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22:02 PM September 13, 2008 Evelyn C. Dalinsky /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □XF 84 13, 1924 Pennsylvania Director 200-14-7174 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 shov any injury or other traumatic event, the Wedless Examiner must be notified at 1X Yes 2 No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 9039 Sligo Creek Parkway, # 501 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 □ No Navy
If Yes, Give
Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 XNo þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Decorating Interior Decorator 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zwibel Fannie George Chotner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8630 Fenton Street, Silver Spring, Md. 20910 George M. Haris-Personal Rep. 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Gdns 9/17/2008 Falls Church, Virginia 4 Donation 5 Other (Specify) 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licenses Tottlemyer 1091 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unionated in that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an autopsy performe 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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DALINSKY

Hospital or Attending EVELYN y within 24 hours after death.

To the Funeral Director: Af Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8500 Old Georget eonard 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State Registrar 16 2008 DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend @5 Per FH 5886 Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)) FNT **Physician** 1406 AMES /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Severna Park Sunrise Senior Living If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5.2320 al Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 85 379-16-2095 May 23, 1923 Michigan Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ural", or items 23a or 28a-f show I Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21146 43 West McKinsey Road Apt. 121 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2□No World If Yes, Give Year or Dates: War II 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any Injury or other trainment. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 √xNo Specify. White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Naval Academy Elementary/Secondary (0-12) College (1-4or 5+) Band Musician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Kipp John Dent ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 43 West McKinsey Road Apt 121 Severna Park, MD 21146 Ruth L. Dent/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 12, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Metro Crematory, Inc. 2008 Baltimore, Maryland 4 ☐ Donation Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature Funer Service License MOS Part1 Enter the disease shoc or heart failure. or complications that caused the death. Do not enter the mode of list only one cause on each lin . ng, such as cardiac or respiratory arrest. Immediate Cause (Final disease of condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himselate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 ☐ Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 212 2□ No 1∐ Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification erson (no completed cause of death (Item 23a) (Type, Print ENDA W 441 6HWAU TEL

State Registrar Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Redistrar's Signature

2008

	Plea	ise Type or	Prir	it in Black In	delible	Ink.	Ensu	ıre A	II Copi	es A	re Le	gible.		
_ For		State of	of Ma	aryland / Depa	artment	of H	lealth a	and N	Mental I	- Hygi	ene			
1 - State Registrar				Cei	rtificate	of I	Death			Reg	g. No. 2	008	31	22
1. Decedent's Name	e (First, Middi	le, Last)							2. Date of	Death		.,	3. Time of	of Death
Evelyn		Ruth			Eckerd	lt			Septe	mbe	Calle,	2008	10:10	PN
4a. Facility Name (/	f not institutio	n, give street and no	ımber)		4b. City, To	own, or	Location of	of Death	1		4c. Cou	inty of Deat	th	
Washingt	on Cou	nty Hospi	tal		Hage	rst	own				Wa	shing	ton	
5. Social Security N	umber	6. Sex	7. Age	(In yrs. last birthday)			If Under Hours	24 Hrs. Min.	8. Date of (Month	Birth	Vaar)		thplace (State	or Foreig
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10a. State	10b. County			10c. City, Town or Lo	cation								10d. Inside (City Limits
MD	Washi	ngton	į	Williamsı	ort								1 □Yes	s 21 No

Funeral Director

Examine

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hiury or other traumatic event, I'm Madical Eva rings must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Funeral Director	16505 Vir	ginia							21795					1	S.A.		
nue	11. Marital Status			. Was Dec Armed F	orces?		S. 1	 Was Dec If Yes, sp 	edent of F ecify Cuba	lispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or Rican, etc.)	No-		ce - Ameck, White	erican Indian, te, etc.	
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Be Completed by	3/F1 Midowed	15. Deceden		Year or E	Jates:		16a De	ecedent's Us	ual Occur	ation			16h	Kind of B			
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O	17. Father's Name (First, Middle,	Last)							18. Mothe	er's Nam	e (First, Mid	dle, Maide	en Surnan	ne)		
To B	Roy Leigh	nton Mo	Cown							Cor	а Ве	11e H	gend	orn			
	19a. Informant's Na	me/Relations	ship (Type.	. Print)			19b. M	ailing Addres	ss (Street	and Numb	er or Rui	ral Route Nu	mber, City	y or Town,	State,	Zip Code)	
	James Ecl	kerdt/S	Son				13	287 Lc	cust	Leve	1 Rd	Gre	eenca	stle	. P/	A 17225	
	20a. Method of Disp					20b. PI	ace of Di	sposition (Na	ame of	- 1		Date				Town, State	
	1 ☐ Burial 2 ∑ 4 ☐ Donation			noval from	State			urg Cr			/19/	2008	Smi	thsb	uro.	, MD	
	21. Signature of Fu			7		1	T								(,,,	Chapel	
	7-0-	10	/ {_	~	~			1601 F								*	
	23a. Part1. Enter the	ne disease, or	r complicat	tions that	caused l	the death	. Do not	enter the mo	de of dyir	ıg, such as	cardiac	or respirator	y arrest,			Approximate Interval Between	
	Immediate Cause (Final	only one	2	each in	e.	D	Cara I William III	rasove							Onset and Death	1
	disease or condition resulting in death)	n	a	Due to	(or as a	consequ	ence of):	eun	مدي							1/days	
					('	
ē	Sequentially list con if any, leading to im- Cause (Disease or	nditions, mediate	b	Due to	(or as a	consequ	ence of):										
휼	Cause (Disease or that initiated events	injury														ĺ	
EX	resulting in death) L	ast	U	Due to	(or as a	consequ	ence of):										
ca			d														
pleted by Physician/Medical Examiner	IF FEMALE:		1														
an/	23b. Was decedent		23c.	. If yes, ou		of pregnar		3 ☐ Ectopic	pregnanc	v			Į.	23d. Da		*	
sici	in the past 12 1 1 ☐ Yes 2 ☐				nant at	time of de		5 Other (,			-	Mo	onth	Day Year	
Phy	9 Unknown			_	-							11					
þ	Part II. Other signifi	icant condition	ons contril		-		_	e underlying	cause giv	en in Part I				,		to the cause of death?	
ted	Congen	tue A	<u>ten</u>	<u>ut 1</u>	<u>-</u>	lur	<u>e</u>					1	∐ Yes —	2 100	3 ∐ P	Probably 4 🗍 Unkno	wn
ple	Diabet	-es N	<u>lell</u>	itu.	_2							24a. W	as an itopsy			utopsy findings availa completion of cause	
Com	Chronic	Obs	5+2u	ctu	12	Lun	a D	isea	50			pe 1 ∐ Ye	erform <u>ed</u> ?	' / ·	death?		
Be (25. Was case referr examiner?						3 "	12000		26. Place	of Deat	h (Check on					
	1 Yes 2 ₩	No	Hos	pital:	Inpatier	nt 2 🗆 E	ER/Outpa	tient 3 🗆 🗅	OA Oth	er: 4□ Nu	ursing Ho	me 5□R	esidence	6 □Oth	ner (Spe	ecify)	
ü	27. Manner of Death	n 5 □ Pendin		28a. Date (Mor	of Injury		28b. Time Injur	e of Y	28c. Injur Worl	y at		28d. Describ	e how in	jury occur	red		
cati	2 Accident	investi	gation					М		Yes 2	No						
Ě	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could i determ	nined	28e. Place build	of Injur ing, etc.	ry - At hor (Specify	me, farm,	street, facto	ry, office				n (Street Town, Sta		er or R	Rural Route Number,	
S		-/															
ica	(Check only	1 C ertifyir 2 Medical		r: On the b	pasis of	examinati										as stated. e to the cause(s)	
Medical Certification: To	one) 29b. Signature and	title of cortific	r	and man	iner stat	ed.			9c. Licens	e number	-		2014 1	Tata ciara	d (Man	th, Day, Year)	
	9	the		T 40:	-7-	<i>L</i> . ,	- ppl	0		451				0		- 17, 200 8	
									_			1 4					
	30. Name and addre	ess of person	who comp	oleted caus	se of de	ath (Item	23a) (Typ	pe, Print)	e Ch	urch	Roo	ed, H	lage	rstoi	ng	Maryla 142	nd
	7	75901111	J.	~1105,	47.	- 102						,			01	142	

State Registrar 31. Date filed (Month, Day, Year) SEP 1 9 2008

32. Tegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	arylan		artment o			Mental Hy		008	31229
4	N Plantin	3	Decedent's Name (First, Middle, Lateral	st)						2. Date of D	eath		3. Time of Death
1	Physici /Media		Velva Edwards							Septem	ber 13	2008	6:40 A M
	Examir	ier	4a. Facility Name (If not institution, given Wilson Health Car	,					ation of Death ersburg			nty of Death Ontgom	erv
	Funeral Director		5. Social Security Number 6. S	ex 7. Age	e (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1 Y	ear If	Under 24 Hrs. ours Min.	8 Date of Bi			place (State or Foreign
	D		Usual Residence of Decedent	A						Aug. 2	.0,1910	-1	
	show	ō	10a. State 10b. County		10c. City	, Town or Lo		_				1	0d. Inside City Limits 1 ☐ Yes 21 No
	the N 28a-f notifie	rect	MD Montgom 10e. Street and Number	ery			Ga:		sburg		10g. Citizen o	of What Cour	
	th with 23a or ist be	al Di	301 Russell Aven	ue					20877		United		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, GiveX Year or Dates:			Was Decedent If Yes, specify 1 ☐ Yes 2 🗓		nic Origin? (S lexican, Puert pecify:	pecify Yes or No Rican, etc.)		Race - Americ Rack, White, cify: White	etc.
21215-0036	ithin 72 ho ne. nan "natur Medical i	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5	+)	(Give life.	dent's Usual O kind of work d DO NOT use re	one durin etired)	l g most of wor	king		Business/In	·
121	iled wi Hygier ther th		12 17. Father's Name (First, Middle, Last,		į		Secreta		Mother's Nam	ne (First, Middle		ectron	ics
lan	ild be f lental i ked of ic eve	To Be	Otto Adkins					10.	Miner			arrie)	
, Maryland	and 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship (Elaine Esaias/Dau			1				ral Route Numl			
Baltimore,	Pages 1 and of He Int. If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.		20b. Pl Me t	emetery, crei	sition (Name of patory or other Ltan ematory	of r place)	Septe	Date ember 2008	20c. Locatio	,	own, State Virginia
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licer	See		22	Name and A	uner	Facility a1 Hom		ast Dec		k Drive,
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each lin	the death	. Do not ent							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	2he	Mer	5 0	tei	nent	a			Ytars
	Examiner			Due to (or as a	a consequ	ience of):							1
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience of):						10	
) _^	execute n and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequ	ience of):				<u> </u>			
68760,	icate be executed physician and s the burial-transit	dical		d									
.O. Box 68	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes → No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3]Ectopic pregr] Other (specif					Date of delive	ery Day Year
Δ.	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death bu	ut not resu	Iting in the u	nderlying caus	e given in	Part I.	7.1	tobacco use co		ne cause of death?
Division or Vital Records,		Completed								24a. Was auto perf 1∐ Yes		b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Vita	Attending Physician: The reath. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other		th (Check only	one)		
ō	ding Phys	. To	1 Yes 2 46	1 ☐ Inpatie	y	ER/Outpatien 28b. Time of		Injury at Work?	Nursing H	ome 5 ☐ Res 28d. Describe	how injury occ		y)
sion	ending I ath. or: After he funer	ation	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury		Work? 1 ∐ Yes	2 □ No				
DİXİ	tal or Attu s after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	iry - At hor c. (Specify	me, farm, str	eet, factory, of	fice			(Street and Nui wn, State)	mber or Rura	I Route Number,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Chapternix 2 Medical Example)	ysician: To the best on niner: On the basis of and manner sta	examinat	vledge, death ion and/or in	occurred at the vestigation, in	ne time, d my opinio	late and place on, death occu	, and due to the rred at the time	cause(s) and , date and plac	manner as s e, and due to	tated. the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	1, 1	1		29c. Li	cense nur		/	29d. Date sig		,
	S	-	30. Name and address of person who	completed cause of de	ell_	MU 232) / 5) rint\	1) [929	1	Septe	mer	13,2008
			John Nel	N'a Cause of de	aui (item	204) (1 900)	Ly 11cl	A	re Co	gither	dui	mol.	13, 200P
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 1 6 20	32 dogis tra	ar's Signat	ure K	anti)			- / - / - /	0		

08-07013 Danny Lee Gruzs 2008 31230

			1- For State Amend Registrar 1. Decedent's Name (F			er och	eenii	icate or	Death			2. E	ate of Deat	g. No		3. Time of Death	\neg
	Physicia al Exami			DANN		THEFT		GRUZS	3			S	^{Month} eptembe	Day r 13, 2008	ear	1940 hrs	
	<u>–</u> × a		4a. Facility Name (if no					4	b. City, Tov		ocation of D	eath		4c. Count		th	
			907 South Fou	ıntain Gre	en Roa	d			Jarretts	ville	вет	Air		Harfor			
	Funeral		5. Social Security Num	ber 6	. Sex	7. Ag	e (In yrs. last	birthday)	If Under		If Under 2	4Hrs. 8.	Date of Bir	, 1987	YY) 9. Bi Fore	irthplace (State or ign	
	Director		219-23-9	444 1	Хм 2	₂ F	21	Yrs.	Months	Days	Hours		lay-9	<u>, 200</u>	8 9	Maryland	
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	any		10a. State 10	b. County			10c. City, To	own or Location								1 Yes 2 X N	
	nd show	7	MD.	Ha	rfor	d					etts	AITI		0g. Citizen of	MALL CO		4
	faryla 28a-f at or	Director	10e. Street and Numb	er					10f. Zip C				1	_			ļ
	a or	늅	3933 Gr	imm]	Road						1084					States	_
	with ns 23 be no	Funeral	11. Marital Status			Was Deceden Armed Forces		13. Wa	s Decedent es, specify	of Hisp Cuban,	anic Origin Mexican, P	? (Specif ∕uerto Ric	fy Yes or No an, etc.)		ace - Ame hite, etc.	erican Indian, Black,	
	death or iten must	Š	1 X Never Married		1	Yes 2	No No							Specil	fv	White	
	after	Ş	3 Widowed		ced If Yes	ites:		6a. Deceden	Yes 2			nd of work	done	16b. Kind of			-
	hours natur Exam	Completed by	15. Decedent's Educ			nest grade co College (1-4 or		during m	ost of worki	ng life.	DO NOT us	se retired))				
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8	withi giene. her tl	E	12 17. Father's Name (Fi	rst. Middle. L	ast)	0		DOA.	11011	1	8. Mother's	Name (Fi	irst, Middle,	Maiden Surna			コ
15	filed al Hy ed of	Be C				ee	G	ruzs				rist		Lore		Swiger	
21215-0036	Ments mark	1 P	19a. Informant's Nam	e/Relationsh				19b. Mailin				er or Rura	al Route Nu	mber, City or	Γown, Sta	ate, Zip Code)	
MD	shc and 7 is	-	Larry 1	L. Gr	uzs	(Fath		3933								MD. 21084	+_
	1 and 2 should Health and M Fitem 27 is m		20a. Method of Dispo	sition				ace of Disposematory or ot		e of cen	netery,	С	Date	20c. Locati	on - City	or Town, State	
Baltimore.	E E S	1	1 X Burial 2	man.		emoval from S	Gal Gal	rdens	of :	Fai	th	9/18	8/08	Rose	dal	e, Maryla	and
Ħ	permit.: Page Department of Important: injury or oth		4 Donation 5 21 Signature Fun	ral Service L	icen e	16	11-	22.1	Name and A	Address	of Facility	E.	G. Ki	irtz 8	c So	n Funeral	1
ä	permit. Depart Impor	i	11/ / / / //	relelon	K	wir		H	ome,	P.	Α	Ja	rrett	svill	е,	Maryland	
Р	hysician		23a. Part I. Enter the failure. List only	disease, or o	complication	ons that cause	ed the death. I	Do not enter	the mode of	f dying,	such as car	rdiac or re	espiratory ar	rest, shock, o	r heart	Approximate Inter- Between Onset a	
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760	ficate be g physicial the burie	1	23b. Was decedent p	regnant in th		3c. If yes, outo		nancy	etal death	3	Ectopic	pregnanc	су	Mor		Day Year	- 1
ä	certificant		past 12 months?		4		at time of dea		ther (Spec	cify)				1			
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C	res that the signed by be detact	2 2	<u> </u>													e autopsy findings availa	
7	requi	1												opsy	prior	to completion of cause	of
9	E law te has												1 🗸 Ye	formed?	-	Yes 2 No	١
Č	certificate			ed to medica	1					26.Plac	e of Death	(Check or	nly one)				_
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4	DIVISION Of VICAL RECORDS, tal or Attending Physician: The law requires after death. al Director: After this certificate has been 8 led in by the finester page 2 should 11 led in by the finester page 2 should 11	∄ F	27. Manner of Death			28a. Date of Sep 13, 20	Injury ay, Year)	28b. Time o	f Injury		ıry at Work			e how injury o o auto coll			
	ION tendin eath.		Natural 2 ✓ Accident	5 Pend	ding stigation			1928 hrs		_	Yes 2 🗸					S. J. D. J. Niverban	City
	/ISI or Att her de birect	λο LI	Suicide		ld not be	28e. Place o	of Injury - At ho	ome, farm, sti	eet, factory	, office	building, et		or Tour	State)		or Rural Route Number,	City
Ċ	pital of	miled in	Homicide		rmined	·	_ocal Stree					_		Green Road			_
	Hosy 24 hc Fun			Certifying P	nysician:	To the best of	f my knowled	ge, death occ	curred at the	e time, c	late and pla n. death oc	ace, and o curred at	due to the ca the time, da	ause(s) and mate and place,	anner as and due	to the cause(s)	
	DIVISION OF VICAL RECORDS, F.O. BOX 509 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funnania Director: After this certificate has been signed by the attending	completely	<u> </u>		an	the basis of o	ed.	muzor mivestiç			se number					(Month, Day, Year)	
	, , , , ,		29b. Signature and	title of certific	er				29		.M.E.				_	4, 2008	
			Monho	we M	ell	rell				0.0							
			30. Name and address			pleted cause stant Medic			Penn St	reet F	Baltimore	e, MD 2	21201				
			Margarita K				strar's Signati	ure 4	, .								
		Sta istr		EP 3	200	n fato	Coper A	J- 62	ander.				<u> </u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Kevin Michael Gi11 14, September 2008 8:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe **Funeral** Min 1 🖫 M 2 🗆 F Months Days Hours 579-98-5565 43 Director March 18, 1965 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Modifical Examination at entitled at anones. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Maryland Baltimore Owings Mills 1

Yes 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 Bright Water Court 21117 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. African 1 □ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. ģ Specify: American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Self Employed years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlisle Michael Gill Judith Young Pinckney ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Gill - Spouse 2209 Walshire Avenue Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery Sept 19, 2008 Washington, DC .22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign ture of Funeral Service 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final immunodoticiency Syndrame C 0 red **Physician** Jean disease or condition resulting in death) /Medical Due to (b) as a consequence of): **Examiner** Immunodeficiency Vivus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

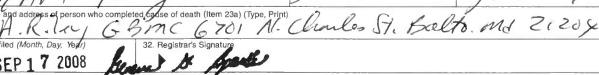
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. ☐ No DICE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after of e Funeral Direc determined 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760. 3111, Kevin 9/14/08

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 7 2008



and manner stated.

29d. Date signed (Month, Day, Year)

within 24 ho

To the Fune

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh 884 10-7-08 yf State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 9-13-2008 BESSIE F. GONZALES 1:30A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🖫 E 93 578-44-0235 7-12-1915 Alabama Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XIXIYes 2 □ No Director MD Prince Georges Seat Pleasant 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20743 6518 Adak Street U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify Specify: 3 ₩Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Dept. ofCommerce vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Dock Henry Knight Josephine Jordan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter <u>Mary E. Brisker</u> 6518 Adak St, Seat Pleasant, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet 09-19-2008 Washington, DC 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Pinckney-Spangler F.H. 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Washington, DC Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e umin to (as a consequence of): ID if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2 X No 9 Unknown 9 Hloknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 ☐ Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2010 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 11 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, Hospital or Attending Physician:

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23 ant: If item traumatic event, Ite Medical Examiner must

permit. Pages
Department of I
Important: If its
any Injury or o
once.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

certificate has been signed by the irector, page 2 should be detached

ours after death.

eral Director: After this certific filled in by the funeral director,

Baltimore, Maryland 21215-0036

with the Maryland

within 24 hours a To the Funeral C 6

State Registrar

Medical

29a. Certifier

29b. Signature

Richard Feldman 31. Date filed (Month, Day, Year)

SEP 1 6 2008

title of certifie

9500 Annapolis Road, #A-4 MD 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

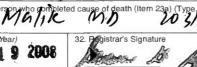
226

29d. Date signed (Month, Day, Year)

Lanham. MD 20706

31. Date filed (Month, Day, Year) State 19

30. Name and addr



Registrar

Ammended #26 Per Phy. 9/16/08 WSH Carroll County Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September Day 13 2008 1318 Carol Ann Gavigan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Westminster Carroll Hospital Center 8. Date of Birth
(Month, Day Year)
June 23 1940 Birthplace (State or Foreign Country)
 W
 VA If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Min. Months Days 1 □ M 2 12 F 68 218-36-6964 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Taneytown MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21787 809 Horseshoe Lane 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Congress Auto Service Co-owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Mae Piercy Francis Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21787 809 Horseshoe Lane Taneytown, MD Richard H. Gavigan, Jr/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 09/18/2008 | Elkridge, MD Meadowridge Mem Pk 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee Pritts Funeral Home and Chapel, P.A. veen

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner is ust be notified at once.

attending physician for use as the buria within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire

Division of Vital Records, P.O. Box 68760,

Medical Certi

	23a. Part 1. Er shock, or
	Immediate Ca disease or cor resulting in de
ical Examiner	Sequentially list any, reading cause. Enter to Cause (Diseas that initiated erresulting in dea
nysician/Med	IF FEMALE: 23b. Was dece in the pas 1 ☐ Yes 9 ☐ Unkr
npleted by Ph	Part II. Other s
To Be Cor	25. Was case examiner?
ication:	27. Manner of 1 Natura 2 Accide 3 Suicid

31. Date filed (Month, Day, Year)

16

2008

1 / may		112 Washington Ro	ad westill	iscer, PD ZIIJ
	lications that caused the death. Do not er ne cause on each line.	ter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	explic Hea	r_De	SPASK IMVIS
Sequentially list conditions, if any, reading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequende of):			
resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Vo 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	24b. Were autopsy findings available
			autopsy performed	prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?	t loopitals Tr		eath (Check only one)	
1 ☐ Yes 2 Z No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing	Home - 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
29a. Certifier 1 Sertifying Ph (Check only cone) 2 Medical Exam	yslcian: To the best of my knowledge, dea ilner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death oc	ice, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 14, 2008 **Physician** 9:11 pM James Patrick Gleason, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery 513 Gilmoure Drive 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye Oct. 14, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number Funeral Year) Days Country) Months 11€ M 2 ☐ F Oct. Ohio Vrc 294-09-5544 86 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County ar than "natural", or items 23a or 28a-f show 1 ☐Yes 2 No Director Montgomery Silver Spring Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IISA 20901 513 Gilmoure Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1⊈Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No White Specify Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) County Executive County Government 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be h and Mental I and 2 should be Marie Millicent Boyle John Edward Gleason 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau 513 Gilmoure Drive, Silver Spring, MD 20901 Georgette S. Gleason/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Pages 1 Gate of Heaven Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 19 Sept 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Silver Spring, MD 20901 500 University Blvd, W., Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Immediate Cause (Final 30 Minutes **Physician** Acute Coronary Insufficiency disease or condition resulting in death) /Medical Examiner 2 years Gleason-Nine Prostate Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): physician at the burial certificate be Physician/Medical attending p Box (IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) TYPS 2 No O detached 9 Unknown q | Unknown signed by to Δ. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 ☐Yes 2x No 1 ☐Yes 2 ☐ No of Vital Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No spital or Attendi ours after death. neral Director; A filled in by the fu death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital **★** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D47682 September 15, 2008 Morris evield 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 Olney-Sandy Spring Road, Olney, MD 20832 Bennett Morrison, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 16 2008 SEP Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Yohannes Berhe Gebremedhin 2008 Sept /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 5. Social Securify Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 XM 2 ☐ F 215-63-5755 55 **Director** Feb 8, 1953 Ethiopia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, It. Mary or other traumatic event, It. Mary or other traumatic event, It. Mary or other traumatic event, It. 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Exeminer must be notified at 1 ☐ Yes 2 X No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3054 Shepperton Terrace 20904 Funeral <u>Ethiopia</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4yrs Parking Attendant Interpark Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Berhe Gebremedhin ပ Roma Nerivo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Asegedech Y. Azene/Wife 3054 Shepperton Terr. Silver Spring, MD. 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-18-2008 Public Cemetery Addid Ababa, Ethiopia 21. Signature of Fune a Service Licensee 22. Name and Address of Facility Murray Funeral Home 4804 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical as the l attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) P.O. I ☐Yes 2 ☐No the detached 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform this certificate 1 ☐ Yes 2 (No 1 ☐Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🔯 DOA Certification: To funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 X Natural ours after death.

neral Director: Al
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

12

2008

Paul B. Baker, MD

SEP

16

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd.

32 Registrar's Signature

D35112

Silver Spring, Md. 20910

9-15-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Aré Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1701 **Physician** GRAY 0 08 GLADYS 11 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) 04/18/1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 K 92 Virgiñia 225-14-2613 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Anne Arundel Director Edgewater Maryland | 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21037 1418 Park Road Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White Baltimore, Maryland 21215-0036 Completed by 3 ☐Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. arked other than Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha A. Shifflett Robert Sipe ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. Ella May Harmel/Daughter 2000 Mitchellville Road, Mitchellville, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 109/17/2008 | McGaheysville, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of F 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. L Immediate Cause (Final Wells VA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Johning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide TSL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar

445DEFENSE HAHWAY atENTA Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20081 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 0ASS 30PM Sepremberl NOLYN 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EURNA MARK 4RUNDA ssisted L -IVING If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 😾 F 215-24-8744 95 Director June 24. 1913 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Precious Exp. in principle to Affiled an once. 1 ☐ Yes 2 ☑ No Funeral Director Anne Arundel MD Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 41 West McKinsey Road Apt. # 207 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unavailable Zola Kansler ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Zimmers/Daughter 4 East Bayard Street Fenwick Island, DE 19944 Sept -20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ерт. 2008 Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. of Funeral Service Licensee Severna Park Funeral H Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PREBROVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Crow to for as a pensycularing offi d uny, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ PRTENSION 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA LIVAG Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

DHMH 17 Rev 1/2001

HIGHWAY MILLERSVILLE MDZ1108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

P 1 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25,26, perPHYS. G883,9/30/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** ,2008 Patricia M. Hopkins 8 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Dicomico hisbury Kehab & Nursing Ctr lisburg Sa 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 F Director 214-30-7932 4/1/1934 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits , and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 1 es 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 550 Village Court 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after ntal Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Health Care 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Howard H. Moffett Jessie Moore or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 Is
any Injury or other trau 3580 Beaver Neck Rd., Cambridge, MD 21613 Patricia M. Hopkins / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Mid Shore Cremation Center 9/22/2008 Cambridge, MD 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown Completed 24a, Was an 24b. Were autopsy findings available Be 은 Certification:

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

						autopsy performed? 1∐ Yes 2 ☑ No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case refer examiner?	red to medical			26.	Place of Death (C	Check only one)	
1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatient 3☐	DOA Other:	Nursing Home	5 Residence 6	Other (Specify)
27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work?	280	d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined			tory, office	28f	f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exa	hysician: To the best of my kr iminer: On the basis of examin	nowledge, death occur nation and/or investiga	red at the time, dation, in my opinion	ate and place, and n, death occurred	d due to the cause(s) a at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

Livic Ave

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 3 0 2.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. William

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Chate of Marylan					•	•		
		State of Marylan	•	artment of F rtificate of L			000	0 21210		
		1. Decedent's Name (First, Middle, Last)		incate or i	Dealli	Reg. No. 2 3 2 1 2. Date of Death 3. Time of Death				
Physicia		OLA ALEXANDER	F	łood		Month SEPTEMBI	ER 12, 20	ar		
/Medica Examine		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of D			
LAGITITIC		8600 Roaming Ridge Way		Odenton			Anne Ar	undel		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)		
Director		416-01-2600 ¹\\ 1\\ 1\\ 1\\ 1\\ 1\\ 1\\ 1\\ 1\\ 1\\	Yrs.			Oct 20,	1915 A	labama		
and t t	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Lo	cation				10d. Inside City Limits		
Maryl -f sho	호	MD Anne Arundel Ode	enton					1 Yes 2 □ No		
r 28a	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?		
h with	ョ	8600 Roaming Ridge Way		21113			U.S.A.			
ems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces? A	S. 13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite. etc.		
or it	by Fu	1 Never Married 2 Married 1 1 Yes 2 No AL	.my	1 □Yes 2 🏝 No	Specify:			31ack		
hours tural"	g p	3 Widowed 4 □ Divorced Year or Dates: 15 Page death Filtration	16a Decer	dent's Usual Occup	ation		16b. Kind of Busine			
in 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	TOD. MING OF DUSINE	ss/mausu y		
with giene.	E	Elementary/Secondary (0-12) College (1-4or 5+)	Lette	er Carrie	r	C	Government	5		
al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, I	Maiden Surname)			
uld b Menta arked	ဥ	Percy Hood			GEORGIA	WILLIAMS	3			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (<i>Type. Print</i>) Gwendolyn Jefferson/daughter	19b. Mailin 8600	ng Address (Street a Roaming	and Number or Rui Ridge Way	al Route Number , Odento	; City or Town, Stat	e, <i>Zip Code)</i> L 13		
1 and Healt em 2		20a. Method of Disposition 20b. P	lace of Dispo	sition (Name of		Date	20c. Location - City	or Town, State		
ages ent of t: If it y or o		ASSIBUTIAL 2 Light Grant Grant State Ma	emetery, cren Vetera	sition (Name of matory or other place ins Cemete	ery Sept		Cheltenh	-		
nit. P artme ortan Injur		4 Donation Other (Specify) 21. Signature of Funeral Service Licensee		2. Name and Addres	1		NS FUNERA			
lmp Per lmp any any		1762	7	474 Lando			er, MD 20			
		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between		
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/Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or es a consequentially list conditions) Sequentially list conditions	uence of):		/ / -					
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ted isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):							
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icate be executed physician and the burial-transit	cal	d.								
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th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal		☐ Ectopic pregnanc	v		23d. Date of			
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d by the etached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resu	ulting in the ur	ndorlying oguso giv	on in Part I	23e Did to	hacco use contribut	e to the cause of death?		
signed be det		Peripheral Vascular Dise			ic Rona			Probably 4 Unknown		
w requir	Completed by	Foilure, Old Cerebrora	•			24a. Was a		autopsy findings available		
he law e has ge 2 s		ra, love, old creprova	300/0	70010	ren/	autops perfori	rior med? prior death	to completion of cause of 1?		
un: Ti		25. Was case referred to medical			26. Place of Deal			′es 2□No		
ysicia is cer direct	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth			ence 6 Other (5	Specify)		
ig Phy ter thi	Ë	27. Manner of Death 28a. Date of Injury	28b. Time of Injury				ow injury occurred	,,		
endin sath. or: Af he fur	atio	2 Accident investigation	,,		Yes 2□No					
r Atter de irecto	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specification of the suiding of the su	ome, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number of n, State)	Rural Route Number,		
oital ours af	ခီ									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) One) (Check only one) One) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
o the	ğ	29b. Signature and jitle of certifier		29c. Licens	e number	2	9d. Date signed (M	onth, Day, Year)		
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		Itt kitt m	D .		3/001		9/17	12008		
0 - 10	_	30. Name and address of person who completed cause of death (Item	23a) (Type,	Print) 7500	3/001	INAY C	9/12	#430		
2 10		Stood V-Turkewitz, M	1D.	Print) 7500	3/001 Green enbelt,	INAY C	9/12 ntr. Dr 20770	#430		
2 10 Stat Registra	е		1D.	Print) 7500	Green	INAY C		#430		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:35 P M Alice Μ. Haynes 2008 10. /Medical <u>September</u> 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Chesapeake Hospice House Linthicum If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2 🗗 F Yrs. 44 437-25-6798 Director Fort Polk, LA 12-28-1963 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Evan in the institut at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Laure1 MD Prince George's 1X Yes 2 □ No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20708 United States 9208 Van Fleet Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sr. Financial Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Bernadine Lewis Marvin E. Haynes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Landover, MD 20785 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once. 6964 Hawthrone St. Adrienne D. Haynes - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 9/17/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Brentwood, MD Rd. 3401 Bladensburg whave horry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician metastatic Cervical disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 XN0 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \textbf{X}Other (Specify) \text{Hospice} Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9-12-2008 121010 D23743 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr. Suite 205 Greenbelt, MD 20770

DHMH 17 Rev 1/2001

State

Registrar

Martin D Weltz, 31. Date filed (Month, Day, Year)

SEP 1 6 2008

Box 68760.

Division of Vital Records,

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

			For State Registrar	State of Mar		rtificate of		Re	eg. No.200				
ı	Physici		1. Decedent's Name (First, Middle, Last) Richard Johnson JR.					2. Date of Death Month SEPTEMBE	Day V	3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, giv	r Location of Death		4c. County of							
200			3036 ROCK DR.	17.	(1 t+ bi-th-d	RIVA	If Under 24 Hrs.	O Data of Birth	ANNE AF	RUNDEL Birthplace (State or Foreign			
	Funeral Director		5. Social Security Number 6. S 217–26–2618 Usual Residence of Decedent	M 2□F 87	(In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 08–27–19	Year) 21 MA	Country) RYLAND			
Maryland		ctor	10a. State 10b. County 10c. City, Town or Location										
	vith the	Funeral Director	10e. Street and Number 3036 ROCK DR.			10f. Zip Code 21140		10	Og. Citizen of Wha				
	heath v	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Puer				Hispanic Origin? (Sp	ecify Yes or No-		American Indian,			
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, I'm M. dical Exertifier I. ust be muffled at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🖔 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, etc. BLACK			
15-0	"natu	Completed	15. Decedent's En (Specify only highest gra	tucation ide completed)	16a. Dece	edent's Usual Occup	oation during most of work d)	ing 1	16b. Kind of Busir	ness/Industry			
212	should be filed withir nd Mental Hygiene. marked other than matic event,	omo	Elementary/Secondary (0-12) College (1-4or 5+) LABORER					GOVERNMENT					
2	oe filectal Hyg	BeC	17. Father's Name (First, Middle, Last		•		18. Mother's Name	·	faiden Surname)				
Maryland	should be and Mental s marked o	유	RICHARD JOHNSON S 19a. Informant's Name/Relationship (40h Mail	in a Address (Caract	ALICE EA		City or Town Ct	ata Zin Cada)			
	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic		GLADYS JOHNSON/WI				RIVA, MD		City or 10 wii, 3a	are, zip code)			
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20b. Place of Disp cemetery, cre	osition (Name of matory or other place	ce)	Date 2	20c. Location - Cit	ty or Town, State			
Ē	t. Pages rtment of rtant: If it		4 Donation 5 Other (Specif	y)	CHURCH C		09-18 ess of Facility		WENSVILI	-			
Ba	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer	isee			VER RD LA						
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	ne death. Do not er	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death			
4	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										
	Examiner			bue to (or as a c	consequence or,								
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	Due to (or as a o					d)				
	execut n and al-tran	Examiner	that initiated events c										
68760,	tificate be executed g physician and as the burial-transit	edical		_d									
			IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of	of delivery			
O. Box	the death cert y the attendin iched for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1						Month				
rds, P.	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions of	ontributing to death but i	not resulting in the t	underlying cause giv	ren in Part I.	4		ute to the cause of death?			
ပ	2 33 a	Completed						24a. Was an autopsy perform	y prio	re autopsy findings available or to completion of cause of atth?			
/Ita	iclan: Sertifica Setor, p	Be C	25. Was case referred to medical examiner?	I I a a site la			26. Place of Deat						
ō	Physiclan: r this certific ral director,	<u>د</u>	1 Yes 2 Ho		2 ER/Outpatie		4 🗆 Nursing Ho	me 5 Reside		(Specify)			
<u>o</u>	Attending r death. ector: After by the fune	ation	27. Manner of Ceath 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No						,,,,,				
\leq	after des after des Director d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, st (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number , State)	or Rural Route Number,			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier Check only one)	nysiclan: To the best of niner: On the basis of e	xamination and/or i	th occurred at the ti nvestigation, in my o	me, date and place, opinion, death occur	Lee, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)					
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	/		29c. Licens	se number	29	9d. Date signed (I	Month, Day, Year)			
			en Kin	and my	0	D30	6761		9/16	198			
L	-6		30. Name and address of person who Michael Rieb	man MD			Stina	4.14.1	Md 21	401			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	VERY MUE	~	1~///	ira ol	701			
	Registr	ar	SEP 1 7 2008	seems 15 1	4								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 State Registrar AM ND#29 OperMD, 9/25/08, BMW, MoCo 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11,2008 September Jennings /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** akom'z Yar K Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace 7. Age (In yrs. last birthday) **Funeral** Year) Days 07-9786 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State la or 28a-f show t be notified at 28a-f show 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number Û items 23a Examiner must Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Giver Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ö þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, the Mea onee. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Jenninas Ohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 20b. Place of Disposition (Name of cemetery, crematory or other place Mt. Oli Vet Ceme 20c. Location State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Washington 21. Signature of Funeral Service 20011 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** INFARCTION 1culE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, many loading to manufacture. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 Other (specify) 9□Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed' this certificate 10 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Medical Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 Spring Street #214; Silver Spring, MD YEHEY15 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

1 - For State Registrar Reg. No. 2008 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician September 13, 2008 7:00 a м Gerald Rodney Keeney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Taneytown 71 George Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Mar 8, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1946 1**X**M 2□ F 62 220-42-6327 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Taneytown Carroll Maryland Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21787 USA 71 George Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ white 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Clabaugh D. Luther Keeney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1020 Reflections Cr Apt 104, Casselberry, FL 32707 Laryssa Keeney, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Keysville Union Cem Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/17/2008 Keymar, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Myers-Durboraw Funeral Home 136 E. Baltimore St, Taneytown, MD 21787 inter Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** FORECTION rayo cerdizi /Medical Due to (or as a consequence of): **Examiner** 10 40 (DADN X Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes M400712 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No morbod 24a. Was an oben h autopsy performed: Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier an 9-15-08 D 43643 crus TATE, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASoN A. 15 Frederice 54 TANEYTYM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

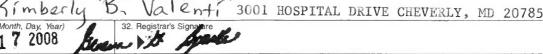
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:15 P Month 09 **Physician** Wilbert Lucas 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges ST. Thomas Moore Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 08-24-1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1⊠ M 2□ F Director 577- 50-7593 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar must be notified at 1X Yes 2 □ No Director Washington DC 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Modical Exercitual must be no once. 20017 USA 5033 10th ST NE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1. Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ₩ No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Capitol Lock & Hardware Elementary/Secondary (0-12) College (1-4or 5+) Locksmith 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbert Lucas, SR Martha Mayo ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5033 10th ST NE Washington, DC 20017 Patricia B. Lucas- Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 9-18-2008 4 Donation 5 ☐ Other (Specify) Laurel, MD 21. Signature of Funeral Service Liq Name and Address of Facility John T Rhines Funeral Home LLC Juan Smith 3005 12th St NE Washington, DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Coronary Atherosclerotic Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Chronic Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 \square No 1 □ Yes 2 (\$tNo or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051122 9/15/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Esmerando 0. Juanitez, MD 1160 Varnum ST Washington, DC 20017 31. Date filed (Month, Day, Year) SEP 1 7 2008 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 11, **Physician** 2008 inston 22:35 ondon /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE HOSPITAL CHEVERLY PRINCE GEORGE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours GUYANA 1 € M 2 □ F 212-17-7841 66 **Director** 10/12/1941 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show s 23a or 28a-f show 1 Yes 2 No Director MD PRINCE GEORGE LANDOVER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8212 SHERIFF ROAD 20785 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) er than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give △ 14. Race - American Indian. Black, White, etc 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐Yes 2 No þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ELECTRICIAN other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be of Health and Menta item 27 is marked r other traumatic e is marked LLOYD LONDON CORA MORTLEY ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHONDELL LONDON/SON 915 WASHINGTON AVENUE #4D BROOKLYN, NY 11225 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 25 ☐ Other (Specify) RIVERDALE CREMATORY 09-20-2008 RIVERDALE, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licens 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kes **Physician** tas disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical the as nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No signed by the a Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ endocarditis 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed bilateral cerebral hemisphere 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has autopsy Stage certificate 2 No □Yes 2) MNo Division of Vital ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 hopatient 2 ER/Outpatient 3 DOA ٩ this After this funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a, Certifier 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DU58153

31. Date filed (Month, Day, Year) 2008 SEP



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year September 16,2008 Russell Maynard LEE 4:00 a.M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Williamsport Nursing Home Williamsport If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months 1 M 2 F 82 454-34-6801 Massachusetts July 21,1926 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 N. Edgewood Dr. Apt.3 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. [XXYes 2 □ No Yes, Give Jear or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) linotype operator publishing company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethan Allen Lee Hazel Faye Maynard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 955 Chestnut Street, Hagerstown, Md. 21740 Marcella J. Jackson - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/17/2008 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signature of Furieral Service Licenses 22 Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Boulevard, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) URO SEPSIS WEEK. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ D0A 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, After this certificate has been si funeral director, page 2 should To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Physician/Medical 9 Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

and Mental Hygiene. Is marked other than

Department of Health ar Important: If item 27 Is any Injury or other trau

Physician

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Examiner

1 and 2 should be fi Health and Mental H

Pages 1

the Medical

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Medical

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DHMH 17 Rev 1/2001

State Registrar

29a. Certifier

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SEP

29b. Signature and title of certifier

2008

29c. License number 3700

WILLIAMSPORT

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

16/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTIZAN

154 N. 32. Registrar's Signature

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 27 per me g884 10-20-08 vt
State of Maryland / Department of Health and Mental Hygiene

state amend item 5 per inf g885 the 10-20 per the Registrar AMEND#10b, c.e. f.perINF9-18-08, BW, Mental Posterior Name (First Middle 100) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** CONRAD В. 10:00 AM LINK September 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gaithersburg Montgomery

9. Birthplace (State or Foreign Country) Wilson Health Care Center Social Security Number 3959 212–38–5898 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours **Funeral** Days Months 1 X M 2 □ F 96 Yrs Director March 5,1912 New York Usual Residence of Decedent 10c. Cify, Town or Location Gaithersburg 10a. State 10d. Inside City Limits ns 23a or 28a-f show must be notified at Montgomery 1 ☐ Yes 2X No MD Funeral Director Howard Columbia 10e. Street and Number 2333 Russell Avenue #319 10f. Zip Code 20877 21044 10g. Citizen of What Country? death with 6009 Snow Crystal United States "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: ^{2□No} 1943-Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White Completed by 3 Widowed 4 Divorced 1944 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor of Horticulture University of MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fill h and Mentai H Be Conrad Link May Elizabeth Barnett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an ant: If item 27 Is r Leora L. Caporaletti (Daughter) 6009 Snow Crystal Columbia, MD 21044 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or Metropolitan Crem. Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cangestive heart Physician dry /Medical Due to (or as consequence of): Examiner rozzary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed buriel-tran Due to (or as a consequence of): Physician/Medical the, phy as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t Ö 9 Unknown ۵. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by ratoma, Evacuation of su 2 No 3 Probably 4 Unknown 1 🗌 Yes Stens 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an , page 2 has Hacemaker 1 receip idenced certificate or Attending Physician: 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ¥Yes 2 No ို this After this funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 2º14M 1 □ Natural 124/08 1 ☐ Yes 2 ☑ No withhealt fleder investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Toyn, State)

1 Poertifying Physician: To the best of my knowledge, death occurred the time, due and place, and due to the cause(s) and mamber as stated. 3 ☐ Suicide 4 Homicide Hospital 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) To 2+1 DO4115 1 XRobert 2 unaus 30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

4. LOBFRT BIRICI-BACH 201 Russell Ave. Gaithersburg, MD 20877 4. ROBERT BIRSCHBACH 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 16 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 10 Physician AM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchest orchester General ambridge HOSPITA 5. Social Security Number If Under 1 Year | If Under 4 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Year) 220-09-1 1 □ M 2 🔏 F Days Hours Min. Director 61 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene.
Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Modical Event actional to notified at
once. 1 Ves 2 □ No Completed by Funeral Director Cambridge Dorchester 10e. Street and Number 10g. Citizen of What Country? nish 1613 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: 3 ☑ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Someone else's home WorK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Hughes, SR, 19a. Informant's Name/Relationship (Type. Print) Fletcher ျှ Mag 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 764 Cornish Drive Cambridge, Mary Janua 21613

page of Disposition (Name of Date 20c. Location - City or Town, State Darlene 20a. Method of Disposition 1 1 Burial 2 □ Cremation 3 □ Removal from State 9/20/08 4 □ Donation 5 □ Other (Specify) Cemetery Cambridge, MD. Bethel 21. Signature of Funeral Service Licensee

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29. Name and Address o Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician myocardial intarction acute 10 days /Medical Due to (or as a consequence of): Examiner coronary aftery disease 20 4 EAS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons uence of): Examiner sician and burial-transit Due to (or as a consequence of): Box 68760, s been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Urindry 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe 2 11No 1 ☐ Yes 2 ☐ No 1 □ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9/10/08 nsan 140059973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar lo hason

Patricia

100 Brambic

Cambridge MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Pauline W. McClain 12:45 P 2008 September 16 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Hagerstown 13507 Donnybrook Dr If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🗓 F Maryland October 25, 1923 <u> 219-14-9056</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 13507 Donnybrook Dr. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2≴☐ If Yes, Give Year or Dates: 2* No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify þ Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistical Clerk Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ilga M. Rice Warrenfeltz Edgar L. Warrenfeltz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hagerstown Paul Warrenfeltz Brother MD 21742 20216 Jefferson Blvd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion U.M. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 09/20/2008 Myersville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home, 1331 Eastern Blvd., Hagerstown, Maryland 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, and mpilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HEMIC Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
HRUNIC DISSTRUCTIVE PULMUNALY DISFASE Be Completed by Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (IMMA) 2 10 NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Mo 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 → Other (Specify) 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, of Vital Records, Division

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

424he Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit completely illied in by the funeral director, page 2 should be detached for use as the burial-transit cate has been signed by the page 2 should be detached

Certification: To

Medical

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

traumatic event, the Mudical Examiner must be nutified at

Department of Health Important: If item 27 any Injury or other trong.

Physician

Examiner

/Medical

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/Medical

To the Hospital
within 24 hours a State Registrar

(Check only Medical Examiner: On the	the best of my knowledge, death oc ne basis of examination and/or invest nanner stated.	curred at the time, date and place, and due igation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
and	manner stated.		
29b. Signature an Vittle of certifier		29c. License number	29d. Date signed (Month, Day, Year)
1 L/Will 50	NOUSIL	1)0017043	9/18/08
30. Name and address of person who completed of	cause of death (Item 23a) (Type, Print	HAGFASTOWN	MD 21742
31. Date filed (Month, Day, Year) 2008 3	2 degistrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death onth Day 10, Year Otember 10, 2008 **Physician** Catherine Juanita Metzger /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine Washington co, Washington Co. Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Year 1912 Months Days Min. 1 M 2 N F Hours January 22, Director Pernsylvania 189-09-8489 96 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State show d other than "natural", or items 23a or 28a-f sho event, the Medical Evariner must be notified at X Yes 2 No Director Pennsylvania Northumberland Sunbury 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code 17801 USA 835 N. 4th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 A.No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Yes. Give Specify: White à 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Textiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental File is marked other Be Ditty William K. Campbell Annie ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)

725 Chestnut Street, Apt. 904 19a. Informant's Name/Relationship (Type. Print) 1 and 2 : Health a permit. Pages 1 and : Department of Health Important; If item 27 any injury or other tr (Son) William F. Metzger 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐Removal from State Pomfret Manor Cemetery 9/14/08 Sunbury, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M-00849Lochstampfor Funeral Home, Inc. 48 S. Church St., Waynesboro, PA 17268
Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cardiogenic shock disease or condition resulting in death) /Medical Examiner sub-cute Myscoldial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir executed and burial-trar Due to (or as a consequence of): Box 68760. physician requires that the death certificate be Physician/Medical the as attending IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭XNo 1 Minpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division Hospital or Attending 1 Natural 5 Pending investigation death. 1 □Yes 2 □No n 24 hours after death le Funeral Director; A eletely filled in by the fi 2 Accident NIA 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a, Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) To the vithin 2. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

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31. Date filed (Month, Day, Year)

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MD- DOD 64943

MEDICAL CAMPUS

NAMBALUA, MD

NANDALVR, MP

gistrar's Signatur

30. Name yd address of person who completed cause of death (Item 23a) (Type, Print)

2008

9/11/08

ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

					epartment of Health a	nd Ment	al Hygi	ene 20	0	31252
			1 - State Registrar		Certificate of Death				00	
	Physici	an	1. Decedent's Name (First, Middle, Last)			l N	ate of Death tonth	Day	Year	3. Time of Death
2	/Medic		Louise M. Moody		44 Oir Town and continued		tembe	r 7,200		7:15 a M
-	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death				
	*##.		Rockville Nursing Home 5. Social Security Number 6. Sex 7. Age (In yi	rs. last birt	Rockville thdav) If Under 1 Year If Under 2	4 Hrs. 8, p	ate of Birth	Mont		
	Funeral Director		413-30-5583 1 M 2 F 88		Yrs. Months Days Hours	Min. (A	Nonth, Day, 1	Yea <i>r)</i>		place (State or Foreign htry)
			Usual Residence of Decedent			J U L	Ly_J,	1720 1		
	how at		10a. State 10b. County 10c. (City, Town	or Location				1	Od. Inside City Limits
	e Ma la-f s tified	cto	Maryland Montgomery Roo	ckvil	1e					1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of WI	nat Cour	ntry?
	ours after death with the Marylar ral", or Items 23a or 28a-f show Examiner must be notified at	Funeral Director	303 Adclare Road		20852			ited St		
	er de Items ner m	nue	11. Marital Status 12. Was Decedent Ever in Armed Forces?	9 65 –	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify) Puerto Rican	res or No- ı, etc.)		, White,	can Indian, etc.
36	rs aft	by F	1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No 19 1	967	1 ☐ Yes 2 No Specify:			Specify:	Whi	lte
Ş	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	ed	15. Decedent's Education	16a.	Decedent's Usual Occupation		1	6b. Kind of Bus	iness/In	dustry
215	hin 7; e. Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	-	(Give kind of work done during most life. DO NOT use retired)	of working]			
21,	d with giene giene grthe	ĕ	4	Re	gistered Nurse			Medi	cal_	
멸	al Hy d othe	Be (17. Father's Name (First, Middle, Last)				st, Middle, M	aiden Surname)	
<u>a</u>	Ment barked	2	Jordan Miller		Ella M	Martin				
lar a	2 sho and Is m		19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street and Number	or Rural Rou	ıte Number,	City or Town, S	tate, Zip	Code)
Baltimore, Maryland 21215-0036	and Health Im 27		Ann DeBlasi-Guardian	60	O Jefferson Plaza	#20] Date	L. Roc	kville. Oc. Location - C	MD	20853
ō	ges it of h		1 ☐ Burial 2 M Cremation 3 ☐ Removal from State	cemeter	y, crematory or other place)	-12-200	08			
Ë	t. Pa rtmer rtant: njury			ort L	incoln Crematory	Cdm-1		rentwoo	d, M	Ш
Bal	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		21. Signardre of Furniral Service Licensee		22. Name and Address of Facility 1040 Rockville				2	20852
			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Don	not enter the mode of dying, such as o	cardiac or res	piratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	oiva	Heart Disease					Onset and Death
	/Medical		Due to (or as a cons	equence o	of):				- 5	
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	xecut and Il-tran	xan	that initiated events resulting in death) Last C. Diahetes Due to (or as a cons	Mell equence	itus				+	
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A W	law requires that the death certifias been signed by the attending 2 should be detached for use as	by Physician/Me	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)			Mon	th	Day Year
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tal Records,	has be	Completed				:	24a. Was an autopsy	ום ו	rior to co	opsy findings available ompletion of cause of
	The cate his	Con					perform 1∐ Yes 2	ed? de	eath?	2□ No
2/5	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			of Death (Ch	eck only one)		
Sign	Physic this of direction of the directio	은	1	ER/Out				nce 6 Othe		fy)
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$\mathcal{MO}_{\mathcal{C}}$ Division	death ctor: y the	icat	- Could not be	t home, fa			ocation (Str	eet and Numbe	r or Rur	al Route Number,
₹ è	after Dire	Certification:	4 Homicide determined building, etc. (Spe	cify)	rm, street, factory, office		City or Town,			
,	To the Hospital or Attending thing 24 hours after death. To the Funeral Director. Algorithm of the funeral price	alC	29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of exam							
	the He in 24 the Fu	Medical	one) and manner stated.	mation an		in occurred at				
	with To t	Σ	29b. Signature and title of certifier	10	29c. License number		29	d. Date signed		Day, Year)
	8		Momas V. Josep		Doo47330			9/8/2	800	
-			30. Name and address of person who completed cause of death (I			.411.	мп 20	0.5.2		
	Sta	ite	Thomas V. Joseph, MD, 50 W. I		Scon Diive, ROCKV	ттте,	гш 20	032		
	Registi		SEP 16 2008	20	South					
			Manufacture and	47	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day **Physician** 20්රී්ර් William Mason Merriman 6:24 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours **tx**□ M 2 □ F 59 Nov 26, **Director** 214-48-2508 1948 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items one any injury or other traumatic event. 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Directo Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4304 Horine Court 21755 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√2 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates 1 ☐ Never Married 2 ★ Married white 1 ☐ Yes X No Specify: 2 Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Government Fleet Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Annie Louise Merriman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Merriman - wife 4304 Horine Court, Jefferson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State **X** Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mark's Cemetery 9-9-2008 Petersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieunsee 22. Name and Address of Facility Stauffer Funeral Home Alle 1100 N. Maple Avenue, Brunswick, Maryland 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Un cardia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causé (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ٩ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: After 28c. Injury at Work? Hospital or Attending 1. Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident hin 24 hours after death the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

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State Registrar 31. Date filed (Month, Day, Year)
SEP 1 6 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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GLO North Ane Registrar's Signature

DHMH 17 Rev 1/2001

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Director

Be Completed by Funeral

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Physician /Medical

Examiner

Funeral

Director

Physician

Plea	se Type or								egible.	
For State Registrar	State o	f Maryland		artment of F rtificate of		ind M		giene Reg. No. 🦿	2 <u>n</u> n	8 3135
Decedent's Name (First, Middle)	, Last)						2. Date of Dea	ath Day	- 4 4	3. Firne of Death
		ANCE STE	LLA M				Septemb	er 13		
4a. Facility Name (If not institution		mber)		4b. City, Town, o		Death			ounty of Dea	
8 South 2nd Str				Woodsb					reder	
5. Social Security Number 197–32–6857	6. Sex 1 □ M 2 □ F	7. Age (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day April 2.	v. Year)	(irthplace (State or Foreig Country) ennsylvania
Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	ocation						10d. Inside City Limit
Maryland Frede	rick	Woods	sbord)						1 Tyes 2 No
10e. Street and Number		1		10f. Zip Code				10g. Citizer	n of What C	Country?
8 South 2nd Str	eet			21798				U.S	S.A.	
11. Marital Status	Armed Fo		13.	Was Decedent of H If Yes, specify Cub	lispanic Orig an, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	. 14.	Race - Am Black, Wh	nerican Indian, nite, etc.
1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	ied 1 ☐ Yes If Yes, Gi Year or D	ve		1 ☐ Yes 2X No	Specify:			Sp	pecify:	White
15. Deceden (Specify only highes	t's Education st grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most	of worki	ing	16b. Kind	of Busines	s/Industry
Elementary/Secondary (0-12)	College (_	DO NOT use retire wner	a)			Pai	inting	g Company
17. Father's Name (First, Middle,	Last)				18. Mother	r's Name	(First, Middle,	Maiden Su	ırname)	
Thomas Giambro					Const	ance	e Laper	9		
19a. Informant's Name/Relations Ronald Massarel		1		ng Address (Street outh 2nd S						
20a. Method of Disposition 1 ☐ Burial 2X☐Cremation 4 ☐ Donation 5 ☐ Other (S		State cerr	etery, cre	osition (Name of matory or other pla g Cremato	· · · · ·	/15/	Oate / 08			or Town, State
21. Signature of Fungral Service	had	er of	61	2 Name and Addre DBERT E I .5 EAST MA	AIN ST	REET	r, THUR	MONT,	HOMES MD 2	P.A. 1788
23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a. NON	caused the death. each line. (-5M 4764) (or as a consequer	CE	ter the mode of dyi	ng, such as	cardiac o	or respiratory a	rest,		Approximate Interval Between Onset and Death 2 YEAR-S
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	(or as a consequer								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2/24No	1 ☐ Live 4 ☐ Preg	itcome pf pregnanc birth 2 □ Fetal do nant at time of dea	eath 3[□Ectopic pregnanc	у			230	d. Date of d Month	lelivery Day Year
9 □ Unknown	9□Unkr	iown								
Part II. Other significant condition BRAW MED	ons contributing to d	leath but not resulti	ng in the u	underlying cause giv	ven in Part I.			obacco use ,• Yes 2 🗌		to the cause of death? Probably 4 □Unknow
							24a. Was autor perfo		prior to death:	autopsy findings availab o completion of cause of ? es 2 \(\) No
25. Was case referred to medica examiner?					26. Place	of Death	h (Check only o	-		

Examiner Completed by Physician/Medical Be 2 Certification: Medical

9 Part II. C 25. Was exa Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 2 No 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 16 SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 9 / 151 2008 29c. License number

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONNOR

6 2008 >

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

131761

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle Last) 2. Date of Death **Physician** 2008 /Medical Factity Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner DULPNIE PIPN If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Pay Year) 04/10/1926 Social Security Number . Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 579-24-3941 82 Washington, D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🐴 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Brookfield Road 21122 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1943-47 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Diesel Mechanic Trailways Bus Company Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental HIMportant: If item 27 Is marked oth any injury or other traumatic event James P. Mitchell, Sr. Irene Jane Corbin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna F. Samples/Daughter 14 Brookfield Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 09/12/2008 | Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Mille 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to wras a consequence of): Tood Bolus Examiner ATYNGER Sequentially list conditions If any, leading to minedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has l 24a. Was an autopsy certificate 2 Z No 1 □ Yes 1 ☐Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of Injury (Manth, Day) 28b. Time of Injury 28d. Describe how injury occurred Year) 1 Natural 5 Pending 2 Accident 9/08 2021 investigation 1 ☐ Yes 2 No ON hoked 6 Could not be lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide AS A DEN A 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

The law requires that the death certificate be executed Box 68760, P.O. Records, Division of Vital Hospital or Attending Physician: To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

Baltimore, Maryland 21215-0036

State Registrar

2008

person who completed

29b. Signature and title of certifier

Tones mo egistrar's Signatur

29d. Date signed (Month, Day, Year) 08

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se of death (Item 23a) (Type, Print)

			For State Registrar	State of Maryla	•	artment of F rtificate of I		Mental Hy	/giene Reg. No20	08	31256
i decis	Physicia /Medic		1. Decedent's Name (First, Middle, Las	PATRICIE	ME	15HAW,	SR	2. Date of Do		Year 08	3. Time of Death
ľ	Examin	_	4a. Facility Name (If not institution, give Anne Arundel Medi	street and number)		4b. City, Town, or	r Location of Dea	th		y of Death Arun	ide1
	Funeral Director		Social Security Number 6. S	7. Age (In yr	s. <i>last birthday)</i> 8 Yrs.	If Under 1 Year Months Days			irth (250)	9. Birthp Cour	place (State or Foreign otry)
	Maryland -f show iled at	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel 10c. C	City, Town or Lo	ocation rnold				1	10d. Inside City Limits 1 □ Yes 🛣 No
	th with the 23a or 28a ist be notif	Funeral Director	10e. Street and Number 530 Greenhill Ct.			10f. Zip Code	1012		10g. Citizen of	What Cour	
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Ifem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1₩ es 2 □ No Vi If Yes, Give Year or Dates:	u.s. 13. etnam	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21X No		Specify Yes or N rto Rican, etc.)	o- 14. Ra Bla Speci	ce - Americ ack, White, fy: W	
0-0171	within 72 ho ene. than "natui ne Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wo d)	orking	16b. Kind of E		ctation
מומ	ld be filed v ental Hygie ked other i ic event, th	To Be Co	17. Father's Name (First, Middle, Last) John I. Meushaw		Truc	.R DIIVEI		ime (First, Middle	e, Maiden Surna		cacton
wal y	1 and 2 shou Health and M e m 27 is mar ther traumat	-	19a. Informant's Name/Relationship (*) Mary Muir Meushaw			ng Address (Street Greenhill		Rural Route Numi nold, MI		, State, Zip	o Code)
בי בי	Page ent o nt: If ry or		20a. Method of Disposition 1 Burial 2XXCremation 3 4 Donation 5 Other (Specific	hemovar from State	lantic	osition (Name of matory or other place Crematory	y 9/1	Date 2/2008	20c. Location Glen Bu	rnie,	MD
	permit. Departm Importal any Inju		21. Signature of Funeral Service Licer	see M		2. Name and Addre		ardesty Annapoli			e, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the de one cause on each line. a. Due to (or as a couse	sis	ter the mode of dyir	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
,00,0	ficate be executed g physician and ts the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse		,					
.O. DOA 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnancy	у			ate of deliv	rery Day Year
L (2)	quires that in signed b uld be deta	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause giv	ren in Part I.	1	tobacco use cor Yes 2 □ No		the cause of death? bably 4
	The law re ate has bee page 2 sho	Completed						24a. Wa auto per 1∐ Yes	opsy formed?	. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of
AIIC	ysician: s certific director,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital: 1 2 Inpatient 2	□ ER/Outpatie	nt 3 DOA Oth	or:	eath <i>(Check only</i>		ther (Snec	(fy)
	ending Phy ath. or: After thi he funeral d	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur Wor		1	how injury occu	- ' '	
2	ital or Att urs after de ral Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Spe	cify) 			City or Te	own, State)		al Route Number,
	he Hosp n 24 hou he Fune pletely fi	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deal nation and/or in	th occurred at the tile	me, date and plac opinion, death oc	ce, and due to the curred at the time	e cause(s) and n e, date and place	anner as s , and due t	stated. to the cause(s)
	To t withi To tl	Me	29b. Signature and title of certifier	Flentar	W	29c. Licens	vi438		29d. Date sign		- ,
i i	HOH		30. Name and address of person who	PENTA M	441	Print) (FEWS	E HAGH	way A.	NN APUL	s au	11,2008 DIKY
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5 2	32. Figistrar's Sig	nature	book		ť			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07199 State of Maryland / Department of Health and Mental Hygiene Skylar Marts 1- For State Certificate of Death Registrar .

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day Y September 21, 2008 2130 hrs Skylar Edward Eugene Marts Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs.. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 3 212-73-5203 1 X M 2 Yrs May 12. 2005 Marvland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No Maryland Washington Hagerstown 28a-f show items 23a or 28a-f should be notified at once. the Maryland Directo 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 140 West North Ave. 21740 U.S.A. with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Mantal Status

1 Never Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 Married Yes Specify: White þ Yes 2 No specify: after Divorced If Yes. Give Year Widowed "natural" à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 1 nent of Health and Mental Hygiene. marked other than 'c event, the Medical 21215-0036 N/A N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Glenda Jean Marts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) B Glenda Jean Marts-mother 140 West North Ave. Hagerstown, MD 21740 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9-27-2008 Hagerstown, Maryland Department o Rose Hill Cemetery Donation 5 Other Specify: 22. Name and Address of Facility Douglas A. Fiery Funeral home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical a Complications of multiple blunt force injuries Immediate Cause (Final disease *(amine)* or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a, 27, 28a-f, perME, g891 5/21/09 TT X UNPENDED ed by the attending physician detached for use as the burial -Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? 1 🗸 Yes 2 1 V Yes 2 No certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be Other₄ examiner? Hospital: 1 / Inpatient 2 Nursing Home 5 Residence 6 DOA ER/Outpatient 3 this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: Natural Yes 2 X No subject assaulted Pendina 9/19/08 5:48 am Accident Investig ation 28f. Location (Street and Number or Rural Route Number, City or Town, State) $540\,$ W. Church St Hagerstown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide residence Hagerstown, (Specify) 4 X Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD.

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 24, 2008

31. Date filed (Month, Day, Year) SEP 3 0 2008 State Registra

29b. Signature and title of certifier

. Registrar's Signatu

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 11, Physician 8:54am M 2008 Agnes Mae Nelson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Olney Montgomery General Hospital Montgomery If Under 1 Year If Under 24 Hrs._ 8. Date of Birth (Month, Day, Year) 11/29/1909 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🗖 F Days Pennsylvania 206-16-6553 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Westleal Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Montgomery Silver, Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20906 3701 International Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Nicholas York Nelson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12521 Kuhl Rd., Wheaton MD 20902 Richard Nelson- Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ft. Lincoln crematory 09/16/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD20904 Mixelin T. Klober 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CENEZUL VUSCULAN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ hupoxemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed ulmonar Lypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

ours after death.

P.O.

To the Hospital within 24 hours a To the Funeral C

State Registrar

Medical

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 Could not be

determined

1 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ata Motamedi 18111 Prince Phillip Dr. suite 101 Olney.MD 20832 32 Registrar's Signature

10 lame

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D063999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Mherell

ANTHM

7 2008

VEIRS 32. Registrar's Signatu

9701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0051158

ROCKVILLE

29d. Date signed (Month, Day, Year)

Mn 20850

SEPTEMBER 13 2008

Physic /Med Exam

Funera

Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Exeminar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

in al	State Registrar		(Certificate of	Death		Reg. No.	
a l	1. Decedent's Name (First, Middle, Last		D ,	0.011/0		2. Date of Dea Month Septem	Day Yes	3. Time of Death 945PM
	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of D	eath/
	FUTURE CARE	Chesapea	KC	day) If Under 1 Year	YOLD If Under 24 Hrs.	R Date of Birt	Anne.	HRUNDEL Birthplace (State or Forei
	100 20 0372	9x 7. Age (In yrs. 73		Months Days	Hours Min.	SEPT 2		INNSYLVANIA
-	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town	or Location				10d. Inside City Lim
ctor	MARYLAND ANNE ARU	NDEL ANN	IAPOL	IS				1 ☐ Yes 2X
ਠ	10e. Street and Number 213 SWITHINS LANE			10f. Zip Code 2140	01		U.S.A.	Country?
by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates:	J.S.	13. Was Decedent of H If Yes, specify Cuba 1 Yes	lispanic Origin? (St an, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		merican Indian, /hite, etc. /HITE
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mo;	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	C	FFICER			U.S. ARMY	·
36	17. Father's Name (First, Middle, Last) EDWARD PIANKA)				ne (First, Middle, NIEDGELS	Maiden Sumame) SKI	
	19a. Informant's Name/Relationship (ROBERT PIANKA - S			Mailing Address (Street ESHELMAN				e, Zip Code)
	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery	Disposition (Name of crematory or other place TON NATIONA		Date	20c. Location - City	
	4 Donation 5 Other (Specification 21. Signature of Funeral Service Liger	,,	CLING	22 Name and Addre	es of Facility DE	MAINE FU	NERAL HON	Œ
	dianaz.	apwney						A, VA 22314
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	th. Do no			4.0	rest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a	nce		IONTI	4		+ YEAR
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ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conser	quençe o	7.				
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þ	Part II. Other significant conditions of	contributing to death but not re-	sulting in	the underlying cause giv	ven in Part I.	23e. Did to		e to the cause of death? Probably 4 Ponkno
Completed						24a. Was autor perio	rmed? prior	
0	25. Was case referred to-medical				26. Place of ea	1 ☐ Yes		Yes 2□ No
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	Funeral			6. Sex 7. Age	(In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24			9. Birth	nplace (State or Foreign
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	be filed within 72 hours after death with the Maryland ttal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		13626 Donnybrool				21742				S.A.	
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Baitimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service L	icensee		22	2. Name and Addres	ss of Facility	Rest Hav	en Fu	uneral C	hapel
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12	11-1		30. Name and address of person w	ho completed cause of de	eath (Item	23a) (Type,	Print) DCO	1 1	.1	., (2.1
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	Registr		31. Date filed (Month, Day, Year)	2008	ARA	K A	Coarts 1					

			For State Registrar	State of Ma		partment of I <i>ertificate of</i>		Mental Hy	giene	008	3 262
			1. Decedent's Name (First, Middle,	Last)				2. Date of De	eath		3. Time of Death
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			Franklin Squa	ire Hospit	9	Rosec	dalle		140	1+im	1018
	Funeral				e (In yrs. last birthda	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	av, Year)	9. Birthp	place (State or Foreign
	Director		217 92 7339	IX M ZLIF	55 Yrs.			Dec 12	2 1952		Iran
and	*		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	Od. Inside City Limits
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1215-0036 within 72 hours after death with the Maryland	", or items 23a or 28a-f sho	Director	Maryland Howard 10e. Street and Number		Ellicott	10f. Zip Code			10g. Citizen of	f What Coun	ntrv?
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leath	ns 2	Funeral	3044 Seneca Chie 11. Marital Status	12. Was Decedent E	Ever in U.S. 1		042 Hispanic Origin? (Sp	ecify Yes or No	o- 14. Ba	USA ace - Americ	can Indian.
ter o	r iter uirse	교	1 ☐ Never Married 2 ☐ Married	Armed Forces?	40	 Was Decedent of F If Yes, specify Cub 		Rican, etc.)	BI	ack, White,	
030 urs a	al',o	þ	3 Widowed 4 Divorced	If Yes, Give A Year or Dates:		1 □Yes 2 No	Specify:		Spec.	ify: Wh	ite
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Maryland 21215-0036	nd Mental Hygiene. marked other than "natural", or imatic event, tre Medical Erami	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Name	e (First, Middle	, Maiden Surna	me)	
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lary!	ल ७ २		19a. Informant's Name/Relationship	, , ,		iling Address (Street					
and S	f Health item 27 i other tra		Saideh Attarha P	ashai / Wif		Seneca C	hief Trai	1 Ellic		-	
ore	of H		20a. Method of Disposition 1	□ Removel from State	20b. Place of Dis	position (Name of rematory or other place	ce)	Date	20c. Location	- City or To	wn, State
Page Hi	ant:		4 Donation 5 Other (Spe		Parklaw	n Memorial	Pk 9/14/	2008	Rockvi	lle, M	Maryland
Baltimore,	Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Lio	ensee		22. Name and Addre	Hin		aldi Fu		
5			231. Part 1. Enter the disease, or co	implications that caused	the death. Do not	11800 New enter the mode of dvi	Hampshire ng. such as cardiac	or respiratory a	ilver Sparrest.	pring,	Md 20904 Approximate Interval Between
Ch	walalaa		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lin	ie.	•		- 27		-0	Interval Between Onset and Death
	nysician Medical		disease or condition resulting in death)	altherose	a consequence of):	Cardiov	ascular	Heall	Disea	se	
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0		ē	Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a consequêncê dîj.						
60, be executed	physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
o exec	an an ial-tr	Exa	resulting in death) Last	C Due to (or as a	a consequence of):						
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68	as th	ed:									****
I Records, P.O. Box 687 The law requires that the death certificate	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		П.Б. А			23d. D	ate of delive	ery
deat	e att	icia	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at		3 □ Ectopic pregnanc 5 □ Other <i>(specify)</i> _	cy 		N	fonth	Day Year
P.O.	s been signed by the should be detached	h Š	9 ☐ Unknown	9 ☐ Unknown —-							
S, F	gned e del		Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use co	tribute to th	ne cause of death?
girie d	en siç	형						1 🗆	Yes 2 ☑ No	3 ☐ Prob	oably 4 ☐ Unknown
Division of Vital Records,	s ber	Completed by						24a. Was	an 24b	. Were autor	psy findings available
A a	age 2	E							psy ormed?	prior to cor death?	mpletion of cause of
ta ta	tifica or, p		25. Was case referred to medical				Of Diese of Death	1 □Yes		1 □Yes	2 ∐No
Slocie C	s cer direct	o Be	exammer? 1☑Yes 2☐No	Hospital:	nt 2 ER/Outpat	ient 3 🗆 DOA Oth	26. Place of Deatl ner: 4 \(\hat{\text{\tin}\text{\tett{\text{\tett{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi}\texi{\texi}\texitint{\texit{\texi{\texi{\texi{\texi{\texi}\texi{\texi{\texi	· · · · · · · · · · · · · · · · · · ·		they (Oif	
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Vision (ith.	Ę	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day on	(, Year) Injury		k? Yes 2 □ No				
ViS	r des ector by th	<u>ië</u>	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Inju	ry - At home, farm,	street, factory, office				ber or Rura	al Route Number,
Dio a	s afte	Certification: To	4 Li Homicide	building, etc	. (Specity)		1	City or To	wn, State)		
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	7_) ord,) .		บิคอ4	54670		01_1	3-0	YE
		+	30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Typ.	e. Print)			1		
			Dr. Robert Groo	Ourold an	m Frank	Deba Hin Squa	ore Drive	P Ral	Limare	MAD	21237
	Stat	е	31. Date filed (Month, Day, Year)	38. Registra	r's Signature	900	- CIC WIIV	- DG1	THOIC	THIP	1000/
	Registra		SEP 16 20	And the second	H. Box	will					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician September Day 2008 Catherine Pantos 7:00 a м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2100 Baltimore Avenue Ocean City Worcester Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) District Months Days Hours Min. 1 □ M 2 🔽 F 73 577-50-7305 **Director** Dec. 12,1934 of Columbia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD Anne Arundel Annapolis Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 438 Peach Court 21409 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 2 **X**No "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 ☐ Widowed 4 😾 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired Executive Dept Maryland Association Elementary/Secondary (0-12) College (1-4or 5+) of Realtors Administrative Assistant permit. Pages 1 and 2 should be filed \
Department of Health and Mental Hygi
Important; If item 27 is marked other
any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis James Pantos Stella Kaufman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen C. Hoffman/ Daughter 438 Peach Court Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest_Memorial Sept. 13 2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD Gardens 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signate of Funeral Service Licen nomy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) atheroscleratic cardiovascular disease **Physician** 4 pertensive unknown /Medical Due to or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) o been signed by the should be detached 9 D Unknown 9 🗆 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown pertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate 1 □Yes 2 ☑No 2 🗆 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hotel 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Birgitta E. Miller MD, 2003 Medica MD 2003 Medical Parkway Snite 100 Annapolis MD 21401 32. Registrar's Signature

and manner stated.

E Milly MI)

2008

Registrar

29c. License number

D50152

29d. Date signed (Month, Day, Year)

Amend Itemstate of Marylands Penantneros allegalth and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hilda Virginia ROOF September 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Julia Manor Health Care Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 252 F 233-34-7366 88 Yrs. Director 25, 1920 West Virginia Usuat Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other then "natural", or items 23e or 28s-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or items 23e or 28a-f ebov treumstic event, the Madical Examinar must be notified at Maryland Washington 1 Yes 2 No Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 139 Belview Avenue 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) switchboard operator hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 shoutd be fill and Mental H Be Charles E. Carder Doris E. Shingleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other treum once. Gary Roof - son Post Office Box 4, Maugansville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 9/16/08 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 2174023a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arobio **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed: 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 Inpatient 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospitel or Attend, within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 09-15-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 034-5 Khalid M. Waseem, M.D., 1126 Opal Court, Hagerstown, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

08-07017 Max Rubin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 31265 Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2. Date of Death Month Day Year September 13, 2008 1. Decedent's Name (First, Middle,Last) Physician/ 2149 hrs Medical Examiner Max Rubin 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring Montgomery General Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Hours Months Days Country) New York Jan. 6, 1916 Director 1 X M 2 92 Yrs. 291-16-0007 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No 28a-f show Silver Spring items 23a or 28a-f sho ust be notified at once. Montgomery MD with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 15107 Interlachen Drive #914 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funera 11. Marital Status White etc. or items Armed Forces? 2 X Married death 1 Never Married 2 X No Yes Itimore, MD 21215-0036

The Pages I and 2 should be filed within 72 hours after dea travel for Health and Mental Hygiene.

Travel If item 27 is marked other than "natural", or it yor other traumatic event, the Medical Examiner musy or other traumatic event, the Medical Examiner musy or other traumatic event, the Medical Examiner musy or other traumatic event, the Medical Examiner musy or other traumatic event, the Medical Examiner musy or other traumatic event, the Medical Examiner musy or other traumatic event, the Medical Examiner musy or other traumatic event, the Medical Examiner musy or other traumatic event, the Medical Examiner musy or other traumatic event the Medical Examiner musy or other traumatic ev specify: White Yes 2 X No specify: If Yes, Give Year Divorced 3 Widowed ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Bio Chemistry Researcher 5+ 18_Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fanny Levanthal Be Benjamin Rubin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ Potomac, MD 20854 11717 Le Havre Drive Diane Tredwell - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, Permit. Pages I and Department of Heal Important: If item injury or other tra 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Olney, Maryland 9/16/08 Judean Mem. Gardens Donation 5 Other Specify 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 21. Signature of F ervice Licensee 1091 Rockville Pike Rockville, MD 20852 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical a. Multiple Injuries Immediate Cause (Final disease *x*aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit rsician/Medical AMENDED g physician a UNPENDED The law requires that the death certificate be 23d Date of delivery Box 68760 23c. If yes, outcome of pregnancy IE FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Fetal death Live birth ed by the attending detached for use as 1 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available Completed 24a Was an certificate has been sector, page 2 should prior to completion of cause of autopsy death? performed? Yes Yes 2 V No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Other₄ Be Hospital: Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 After this 1 Yes No 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Passenger auto fixed object collision Certification: Sep 13. 2008 1908 hrs Yes 2 V No Natural 1 Director: Pending hours after death. 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) Norbeck Road and Georgia Avenue, Rockville, MD Suicide determined (Specify) Local Street within 24 hours a Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) g and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 14, 2008 O.C.M.E. 'or sha 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. 32 Registrar's Signature 31. Date filed (Month Day Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

				State of Mary	land / Depa <i>Cei</i>	artment of H	lealth and M <i>Death</i>		ene2 () () () ()	31266
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of Vital	Physician: this certific ral director,	2	10 165 2010	1 L Inpatient	2 ER/Outpatien	3 DOA	4 LI Nursing nor	ne 5 Residen		city/455t. LIVING
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Si	Attanding ir deeth. actor: Aftei by tha fune	Sal	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm str			PRf Location (Stre	eet and Number or Ri	ıral Route Number
Division	or Attandl eftar deeth. Director: A d in by tha f	Certification:	4 ☐ Homicide determined	building, etc. (S)	pecify)	or, lactory, office		City or Town,		
_		edicai C	29a. Certifier (Check only one) Certifying Physic 2 Medical Examiner	an: To the best of my : On the basis of exa- and manner stated.	knowledge, death minetion end/or inv	occurred at the timestigation, in my op	ne, date and place, e pinion, death occurre	and due to the cau and at the time, dat	use(s) and manner es te and place, and due	stated. to the cause(s)
	o the		29b. Signature end title of certifier			29c. License	number	29	d. Date signed (Mont	h, Dey, Yeer)
	F 5 F Ö		Ill =	9		11.0	1117	(9-15-1	8
	5	-	30. Neme and address of person who comp	latart hause of doct	/Item 22a\ /Time !	Print)	١١٢ر		1100	21702
			Hemen shah	65 c T		- 1	can X	in En.	9-15-0	MA
	Stat	6	31. Date filed (Month, Day, Year)	32. Registrer's S	Omas Gignature	Jonn	2-11 2	, , ,		
	Registra		SEP 1 6 2008	Marie	1. Apar	W				

DHMH 16 Rev 6/95

		For	State of M	aryland.		rtment of F		d Mental Hy	- (2008	31267
		Registrar 1. Decedent's Name (First, Middle,	Lact		Cer	lilicale of	Dealii	2. Date of De	Reg. No.		3. Time of Death
Physicia	an		Lasty		-			Month	Day	Year	
/Medic	and the	Theodore			Russ		al anation of D	Septemb		0 2008 ounty of Death	12:40 A M
Examin	er	4a. Facility Name (If not institution,				4b. City, Town, o		eatri	40.0	i di	
	-0	1827 Greenlees 5. Social Security Number 6		rth je (In yrs. last	t hirthday)	Frede If Under 1 Year		rs. 8. Date of Bir	th	Frederi	
Funeral Director		140-30-7403	1⊠M 2□F	68	Yrs.	Months Days		lin. (Month, Da	v. Year)	Coul	place (State or Foreign htry) York
Sec		Usual Residence of Decedent		00			1	Sury 2,	1770	new	TOTA
ylanc low at		10a. State 10b. County		10c. City, T	own or Loc	ation				1	Od. Inside City Limits
Mar a-f st	눥	Maryland Frede	rick	F	reder	ick					1 ☑ Yes 2 ☐ No
h the	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
teath with the Marylar ns 23a or 28a-f show must be notified at		1827 Greenlees	e Drive			21	701			United	States
dear dear	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	as Decedent of H	lispanic Origin? an. Mexican. Pi	(Specify Yes or No uerto Rican, etc.))- 14	I. Race - Americ Black, White,	
after d		1 ☐ Never Married 2 ☑ Married	d 1 √Yes 2 □	No		☐ Yes 2 XINo		,	- 1	Specify: Bla	
iours iral", I Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1962-63							
72 h "nati	ete	15. Decedent's (Specify only highest		1	(Give I	ent's Usual Occup kind of work done ONOT use retire	during most of	working	16b. Kind	d of Business/In	dustry
vithin ne. han	ш	Elementary/Secondary (0-12)	College (1-4or	5+)		trical E	,		1	ospace	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Completed	17. Father's Name (First, Middle, La			ETec	LIICAI E		Name (First, Middle			
lbe f ntal F ed ot evel		Benjamin Rubi:	•					Vaomi Chap		umame)	
should and Men marke	٦	19a. Informant's Name/Relationship			19b Mailin	n Address (Street		r Rural Route Numb		Town State 7in	Codo)
d 2 sl th an 7 Is r traur								e, North			Maryland
1 and Health em 27		Debra C. Russel 20a. Method of Disposition	I / WIIE	20b. Plac	e of Dispos	sition (Name of	i	Date		ation - City or To	
Pages nent of l int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3		cem	etery, cřem	atory or other pla	: Se	ptember			
it. Partment		4 □ Donation 5 □ Other (Special Service Li		Mt.		t Cemete Name and Addre					Maryland
permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mential Hygiene. Important: If item 27 Is marked other than "natural any Injury or other traumatic event, the Medisal Exonce.		21. Signature of Fuller Service Li	A A					Stauffer			
		22a Part Enter the disease are	omplications that cause	d the death I						ek, Mary	Approximate
		23a. Part1. Enter the disease, of c shock, or heart failure. List of Immediate Cause (Final									Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	_a w	16.0	10	100	5	netas	6-15.	-3	3 MO
Examiner			Due to (or as	a consequen	ice of):					_/	
	-	Sequentially list conditions,	b. Due to (or as	a consequen	ice of):	c// C	7-51	10-10) (9/-	
xecuted and Il-transit	nju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		<	7	15.	d	*			15 10
execu n and al-tra	Examiner	that initiated events resulting in death) Last	C Due to (or as	a consequen	ice of):	, , , ,					
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transi	dical I		d								
fficate g phys			0								
eath certific attending p for use as 1	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23	3d. Date of deliv	ery
death a atte	cia	in the pas. 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4∐Pregnant a			Ectopic pregnanc Other <i>(specify)</i> _	y			Month	Day Year
tt the deby the by the tached	hys	9 ☐ Unknown	9∐Unknown								
s that ned t	by P	Part II. Other significant condition	s contributing to death t	out not resultir	ng in the un	derlying cause giv	ven in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?
quires n sign uld be								_ 1 🗆	Yes 2	No 3∏ Pro	bably 4 □Unknown
aw requir s been si s should I	Completed							24a. Was		24b. Were auto	opsy findings available
The la	E C								ormed?	death?	ompletion of cause of
sician: The law certificate has t irector, page 2 s		25. Was case referred to medical					26 Place of	1 Yes Death (Check only	2 No	1 ☐ Yes	2 □ No
ysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	ent 2□ER	VOutpatient	3 DOA Oth	205.	ng Home 5, ■Res		Other (Speci	(f _V)
₹ ∓ ≅		27. Manner of Death	28a. Date of Inju	ury 28	3b. Time of	28c. Inju		28d. Describe			
nding F ith. r: After e funera	i i	1 Natural 5 Pending 2 Accident investiga		ay rear)	Injury		Yes 2 □ No				
Atte r dea ecto by th	ili Ci	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of In	jury - At home tc. (Specify)	e, farm, stre	eet, factory, office				Number or Rur	al Route Number,
To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Certification:	4 I Tomode	bullarily, e	tc. (Specify)				City Of TO	wn, State)		
the Hospital hin 24 hours a the Funeral upletely filled		29a. Certifier	Physician: To the best	of my knowle	edge, death	occurred at the ti	ime, date and p	lace, and due to the	cause(s) a	and manner as	stated.
n 24 n 24 ne Fu	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner si	tated.	n and/or inv	estigation, in my	opinion, death	occurred at the time	, date and j	place, and due	to the cause(s)
To the within To the complete	Ź	29b. Signature and title of certifier				29c. Licens				signed (Month,	
			Carlo			01	4621		5-1	16 10	2005
10		30. Name and address of person w	ho completed cause of	death (Item 23	3a) (Type, I	Print)	V - 10 340	Frede.			,
10		VG V	2010565	501		1753	50	Frede.	1.5	MO	20101
Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	6	10					

DHMH 17 Rev 1/2001

State Registrar

, 1	Type of Frint in Black indelible link. Ensure All Copies Are Leg	ible		
	State of Maryland / Department of Health and Mental Hygiene 2	08	3	3

			1 - For State Registrar	State of Mar	ryland /		artment of F			jienę2 (308	31268
	D		1. Decedent's Name (First, Middle, Last)				-	2. Date of Dea	th	Vaar	3. Time of Death
ı	Physici: /Medic		JOSEPH	WALTER	REID				Septemb	per 13	, 2008	10:00 PM
and the second	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Deat	h	4c. Cou	inty of Death	
			Frederick Memon	rial Hospi	tal		Freder	ck If Under 24 Hrs	7	Fr	ederic	
	Funeral		5. Social Security Number 6. Se	x 7.7Age QM2□F	(In yrs. last t	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	I (MOTILI). Day	Year)	l Cour	place (State or Foreign
	Director		218-52-7367	`	4 /		<u> </u>		MAR 4	1961	WASI	H., DC
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
	a-fst	ctor	MD FREDE	RICK	WAL	KER	SVILLE					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code	_	1	-	of What Coun	itry?
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the than "natural", or items 23a or 28a-f show ent, the Medical Evandrer must be notified at ent.	ral	8381 DISCOVERY	BLVD			2179	3		Ţ	JSA 	
	tems term	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. F	Race - Americ Black, White, 6	
36	s afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:	0		1 □ Yes 2 X No	Specify:		Spe	ecify: WH	rme:
21215-0036	hour	ed	15. Decedent's Edu		16	a. Dece	dent's Usual Occup	ation		16b. Kind o	f Business/Inc	
212	nin 72 I. In "ne	plet	(Specify only highest grad	le completed) College (1-4or 5+)	- 1	(Give	kind of work done DO NOT use retired	during most of wor	rking			,
21.	d with giene er tha	Completed	12	College (1-401 3+,		TRU	CK DRIV	ER		LANDS	SCAPI	NG
Maryland	al Hy al Hy I othe	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nar	me (First, Middle, i	Maiden Surr	name)	
<u>yla</u>	Meni Meni arkec	2	JAY HERBERT RE	ID					NIA HEL			
Лаг	2 sho and r is m raum		19a. Informant's Name/Relationship (T									^{Code)} 21793
e o	s 1 and if Health item 27 other to			POUSE			DISCOVI	ERY BLV			on - City or To	
Baltimore,	Pages 1 and tment of Health tant: If item 27 jury or other t		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	ST	tery, crer MAR	sition <i>(Name of</i> natory or other plac Y CHUR	ён 9/1	8/08		-	LLE, MD
=======================================			4 □ Donation 5 □ Other (Specify,			EME	TERY	i	-,			
Ba	permi Depar Impor any ir		21. Signature of Fan Sirvice Livens			22	2. Name and Addre HILTON	FUNERA	L HOME			
			23a. Part 1. Enter the disease, or comp	ications that caused t	he death. De	o not ent			BARNESV c or respiratory arr		, MD	20838 Approximate
	N1-1		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line					· · · · · · · · · · · · · · · · · ·			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a			PNEUMUI	VIIT				
,*	Examiner						STASIS	•				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	e oi).				_		
	ocuted nd transi	Examin	that initiated events	c. MAIE	METH	9511	ATIC B	REAST	CANCEL	2		
/60,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a	consequence	e of):						
200	w requires that the death certificate be executed to be executed seen signed by the attending physician and should be detached for use as the burial-transit	dical		d					• • • •			
RG X	death certificate e attending physi d for use as the l	Physician/Med	IF FEMALE:	23c. If yes, outcome of	f pregnancy							
X Q Q	atten for us	cian	in the past 12 months?	1 ☐ Live birth 2	È ☐ Fetal dea		Ectopic pregnanc Other (specify)	у		230.	Date of delive Month	ery Day Year
	the d	ysi	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	ano or dodar							
7.	requires that the been signed by th hould be detache	by PI	Part II. Other significant conditions co		not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?
ecords,	quires	d bé	PANCYTOPEN.	TIA					1 🗆 Y	es 2 □ No	o 3□ Prot	pably 4⊠ Unknown
ပ္တ	law recast bee	Completed							24a. Was a		b. Were auto	psy findings available
r	The la ate ha page 2	mo							autops perfor	med? 2 2 No	prior to con death? 1 ☐ Yes	mpletion of cause of
	ian: rtifica stor, p	(D)	25. Was case referred to medical			*		26. Place of Dea	ath (Check only or		1 🗆 162	2010
	ding Physician: The law h. After this certificate has funeral director, page 2 s	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	t 2 ER/0	Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing H	Home 5 ☐ Resid	ence 6	Other (Specif	y)
_	ng Pl	_:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) 28b	. Time of Injury	f 28c. Injur Worl	y at k?	28d. Describe h	ow injury oc	curred	
DIVISION	al or Attending F s after death. I Director: After d in by the funera	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 □ No				
<u> </u>	or At fter d Sirect in by	ıţ	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, str	eet, factory, office		28f. Location (S City or Town	treet and Nu n, State)	ımber or Rura	al Route Number,
_	pital ours a erai [filled		29a. Certifier 1 CertifyIng Phy	sician: To the best of	f my knowlod	lao danti	h accurred at the ti	ma data and plac	o and due to the	20122(2) 222	d mannar as (stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) Medical Exam	iner: On the basis of and manner state	examination .	and/or in	vestigation, in my	ppinion, death occ	urred at the time, o	late and place	ce, and due to	the cause(s)
	Nithin To the Tompl	Me	29b. Signature and title of certifier				29c. Licens	e number	2	29d. Date sig	gned (Month,	Day, Year)
	7-0		July CAMININE	es las sin	wa en	D	200	63498		91	14/08	
	7		30. Name and address of person who co									
	-		LAKHVINDER			00 7	W. 7th S	ST., FR	EDERICK	MD	21701	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar			1 4	-				

			For State	State	of Maryla		artment of F		l Mental Hy	200	8 31269
			Registrar 1. Decedent's Name (First, Middle)	Last)			tineate or	Deain	2. Date of De	ath	3. Time of Death
	Physici /Medio		OUMOU		5	OW			Month 09	Day Yea	of 1133 M
, é	Examin	er	4a. Facility Name (If not institution, 2202 Dunrobin	-	ımber)		4b. City, Town, o	r Location of De	ath	4c. County of De	
. 1 241	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	Bowie If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	Prince G	eorge's irthplace (State or Foreign Country)
ı	Director		215-57-1308	1 □ M 2 D =	42	Yrs.	Months Days	Hours Mi	oct. 1	8, 1965 _{Con}	irthplace (State or Foreign Country) akry, Guinea
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	a-f st	ctor	MD Prince	George's	Bow	ie					1★2 Yes 2 □ No
	with th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What 0	Country?
	ns 23	eral	2202 Dunrobin		edent Ever in l	J.S. 13. V	20721 Was Decedent of H	lispanic Origin?	(Specify Yes or No	Guinea	nerican Indian.
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ir a Madical Examinar must be reaffed at once.	by Funeral Director	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	orces? 2 ⊠No ive		fYes, specify Cuba I∐Yes 2 X No	an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	Black, Wh	ite, etc.
212-0036	72 hour		15. Decedent's (Specify only highest	s Education	Jales:	16a. Deced	dent's Usual Occup	ation	orking.	16b. Kind of Busines	s/Industry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurse	DO NOT use retired	during most of w	Orking	Private	
שנ	al Hygi other vent, I	Be C	17. Father's Name (First, Middle, L	,		Tiuz Be		18. Mother's N	ame (First, Middle,	Maiden Surname)	
yland	ould bu Menta larked	2	El Hadji Boubac	ar Soe				Hadji I	Lama Sow		
Mar	d 2 sh th and th sm 7 is m traum		19a. Informant's Name/Relationsh Foday Kamara/hu						Rural Route Numb Bowie, M	er, City or Town, State	, Zip Code)
e,	s 1 an of Heal item 2 other	1 3	20a. Method of Disposition		20b.		sition (Name of natory or other place		Dowle, M	20c. Location - City of	or Town, State
Dallimor	Page ment c ant; If ury or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		shington	· i	5/2008	Aldelphi,	MD
	permit. Depart Import any inj once.		21. Signature of Funeral Score L	ionsee				ss of Facility J	.B. Jenk	ins Funera	1 Home
			23a. Part 1. Enter the disease, or o	complications that of	caused the dea					, MD 20785	Approximate Interval Between
1	Physician /Medical		shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a.	each line.	BAG	7457				Interval Between Onset and Death
and a	Examiner			Due to	(or as a conse	quence of):					
	ed sit	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to	(or as a conse	quence of):					
,	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c	(or as a conse	quence of):					<u> </u>
0,00	ficate be executed physician and s the burial-transit	dical		d							
ŏ :	leath certific attending pl for use as t	/Med	IF FEMALE:	220 If you out	tooms of avega	anav.					
	ed be	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	tcome of pregn birth 2☐Fet nant at time of nown	al death 3 □	Ectopic pregnance Other (specify)	У		23d. Date of d Month	elivery Day Year
Ď.	ss that gned b	by Phy	Part II. Other significant condition	s contributing to d	eath but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
5	w requires been sign should be					-			1 🗆 `	/es 2 No 3 □ 1	Probably 4 Unknown
ָ בּ	The law ate has b	Completed					<u> </u>		24a. Was autop perfo 1 □Yes		
A	i ii o	Be	25. Was case referred to medical examiner?	Hasnital:					eath (Check only o		2 2 1100
5 2	This in	٦	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 28a. Date		ER/Outpatien		4 🗀 Nursing		dence 6 Other (Sp	pecify)
5	Attending in a death. ector: After by the funerant	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mon	th, Day, Year)	Injury	28c. Injury Work M 1 🗆	? Yes 2 □ No	200. Describe i	low injury occurred	
	al or Atte s after de al Directo	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place	of Injury - At h ng, etc. (Speci	nome, farm, stre	et, factory, office		28f. Location (S City or Tov	Street and Number or I vn, State)	Rural Route Number,
		Medical (29a. Certifier (Check only one) Certifying 2 Medical E	xaminer: On the b	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred at the tir restigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
	withii To the comp	M	29b. Signature and title of certifier	A)	tou	41	29c. License	number	38	29d. Date signed (Mor	nth, Day, Year)
2	-3		30. Name and address of person w	ho completed caus	e of death (Ite	m 23a) (Type, F	Diese le	E Anci	HWAY AN	APace A	10 Elvas
	Stat		31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	ature	- 61 603	1/10/	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-01/100)	1.80/
	Registra	ir	SEP 1 7 2008	Flance	5	(Just	D .				

			1 - State of Maryland / Department Certificate			giene200	8 31270
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Yes	3. Time of Death
	Physici /Medio		Elizabeth M. Smith		Sept.	7 2008	10:00a M
	Examin	ner		own, or Location of Death	1	4c. County of D	
Je*			Laurel Health and Rehabilitation Ctr Laur 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		0 Date of Birth		George's
	Funeral Director			Days Hours Min.	8. Date of Birth (Month, Day	Year) No.	Birthplace (State or Foreign Country) rth Carolina
-	0		Usual Residence of Decedent		10/10/	1919 10	ith Carolina
	urylan show	_	10a. State 10b. County 10c. City, Town or Location Maryland Prince George's Hyattsville				10d. Inside City Limits
	Ba-f s	Director					1 ☑ Yes 2 ☐ No
	a or 2	ä	10e. Street and Number 10f. Zip C		1	0g. Citizen of What	Country?
	ns 23	Funeral		781	pocify Voc or No	USA	merican Indian,
ر د	be filed within 72 hours after death with the Maryland hall Hygiene. do other than "natural", or items 23a or 28a-f show event, it a Modical Exacultive miss by notified at	by Fun	Armed Forces? 1 □ XNever Married 2 □ Married 1 □ Yes 2 □ XNo If Yes, specif 1 □ Yes 2 □ Xno If Yes, Give Year or Dates:	ent of Hispanic Origin? (Sify Cuban, Mexican, Puerto	Rican, etc.)	Black, W	
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F	3 = 8			1002472	1	SOBY 12	R DONE
. ^	2	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1002712	-1 '	7 10	- 6000
1	-0		Syed Akbar Sadiq, MD 14200	Laurel Park	Dr., La	urel, MD	20707
	Stat Registra		31. Date filed (Month, Day, Year) SEP 1 6 2008 32. Registrar's Signature				
	negistra	:11	SELTO COM CHANGE TO MANAGE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:10 P M September 11 2008 <u>Irene Hazel Snyder</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County 19832 Bennie Dr. Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 219-20-1003 Yrs. 80 Director May 5,1928 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Items 23a or 28a-f shows increased by rectal 1 ☐ Yes 2 No Washington County Hagerstown Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 U.S.A. 19832 Bennie Dr. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Truck Mfg. .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 Is marked other t ijury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esta M. Reynolds Faulders Solmen L. Faulders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 West Wilson Blvd. Hagerstown, MD 21740 Judy Schaeffer-daughter permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-16-2008 Greenlawn Mem. Park Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 Other (specify) signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 INO 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify) Hospital: 1 Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P after death. I Director: After i 1 Natural 2 ☐ Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital within 24 hours a completely

State Registrar

30. Name and address of person who completed cay

29b. Signature and title of certifier



e of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Anita Mae Straub 15 2008 September 0630 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1000 Weller Circle #221 Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 20 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🔀 F Months Days Hours 163-18-6382 PA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐¥es 2 ☐ No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Weller Circle #221 21158 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 ☐ Xo Specify **∂** 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Zimmerman Louise Freitag ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert G. Straub/Husband 1000 Weller Circle #221 Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc 09/16/2008 Hampstead, MD of Fun - al Service License Pritts Furerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I'm Modical Evantment into the routhed at any Injury or other traumatic event, I'm Modical Evantment into the routhed at any Injury or other traumatic event, I'm Modical Evantment into the routhed at any Injury or other traumatic event, I'm Modical Evantment into the routhed at any Injury or other traumatic event, I'm Modical Evantment into the routhed at one of the routhed at any Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event, I'm Modical Evantment in Injury or other traumatic event in Injury or other traumatic event in Injury or other traumatic event in Injury or other traumatic event in Injury or other event in Injury or

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial-transit rely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To

27. Manner of Death 1 ☑ Natural

2 Accident

3 Suicide

29a. Certifier.

4 \ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

1 SEP

determined

Division of Vital Records, P.O. Box 68760. 24 hours a To the Hosp within 24 hou To the Fune completely fi

10

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

28a. Date of Injury (Month, Day, Year)

and manner stated

28c. Injury at Work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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	Funeral Director		5. Social Security Number 041-26-8695 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 74	Yrs.	Months Days		Min	Date of Birth (Month, Day uly 3	, Year) , 19:		Wisconsin
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral Director	10a. State 10b. Count Maryland 10e. Street and Number 3501 Forest	Montgomer	у	y, Town or Lo	rer Sprin 10f. Zip Code 2090				10g. Citiz US.	zen of Wha	10d. Inside City Limits 1 □ Yes 2 ☑ X0No t Country?
9800	ours after death ral", or items 23 Examiner mus	δ	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	12. Was Dec Armed F	cedent Ever in U. Forces?	wn	Was Decedent of If Yes, specify Cut	Specify:	n? (Specify Puerto Rica	/ Yes or No- an, etc.)		Black, V Specify: W	
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (21. Signature of Funeral Service	(Specify)		rview	osition (Name of matory or other place Cemetery 2. Name and Additional Cancis J	ress of Facility	ept. 200 ns Fu	20 8 meral	W. Hom	artfo e Inc	rd, Connecticut
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Division of Vital Records,	ttending Physideath. tor: After this can the funeral direction	Certification: To	1 Yes 2 TNo 27. Manner of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coul	28a. Da	□ Inpatient 2 □ te of Injury onth, Day, Year)	28b. Time of Injury	of 28c. Inj M 1	ury at ork? □Yes 2□N	0 280	d. Describe	how injur	y occurred	
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	To the Hospital or Atti within 24 hours after de To the Funeral Directo completely filled in by the	Medical	(Check only 2 Medic one) 29b. Signature and title of certifications	al Examiner: On the and ma	e basis of examinanner stated.	ation and/or i	29c. Lice	opinion, deat	h occurred	at the time,	, date and 29d. Da	te signed (d due to the cause(s) Month, Day, Year) er 15, 2008
			30. Name and address of personal rate of	10301		Avenue	Print) e, Silve	Sprin	g, MC	2090	2		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State	e of Ma	arylan	d / Depa			lealth a			Reg. No.₄	2008		74
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/Medic Examin		4a. Facility Name (If not institution Shady Grove Ad			pital	L		Town, or	Location o	f Death			County of Dea		
Funeral Director		5. Social Security Number 578-92-4443	6. Sex 1 🙀 M 2 🗆	7. Ag	e (In yrs.	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	Date of Bird (Month, Da pril 1	y, Year)	Co	thplace (State or Fountry) Shington,	
e Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	ce Georg	je's	10c. Cit	ty, Town or Lo	el.					10- 0"		10d. Inside City L	
h with th		10e. Street and Number 15510 Park Ha	all Cour	rt			207	O7				US	zen of What Co A	ountry ?	
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or Attending Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be d	Certification: To							28c. Inju Wo 1 [Injury at Work? 1 Yes 2 No						er.
spital or A ours after i eral Direc filled in by		4 ☐ Homicide deterr	ng Physician:	To the best	t of my kn	owledge, dea	th occurre	ed at the t	ime, date a	nd place, a	City or To	wn, State	e) s) and manner	as stated.	
To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medica 29b. Signature and title of contin	Examiner: On	the basis I manner s	of examin	ation and/or i	nvestigati	on, in my	opinion, dea	ath occurre	ed at the time	, date an	d place, and du	ie to the cause(s)	
20	•	30. Name and address of person	who completed		4 .	_ /	, Print)	DE	320	24	1 1	SCI 11-	1016	ex 13 2 20850	œ
Sta	ate	31. Date filed (Month, Day, Year	99	2/ 32 Règist	TEA trar's Sign	ICA/	CH	ter	lh		ackui	1/e	170 .	20850	1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 11, 2008 5:15 P M Joseph Van Sterling September /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Linthicum Heart Home at Linthicum 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9/9/1922 7. Age (In yrs. last birthday) 5. Social Security Number Year) Maryland **Funeral** Min. Months Days Hours 1 € M 2 □ F 86 219-16-9288 Director Usual Residence of Decedent 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic events. 10c. City, Town or Location 10a. State 1 ∐Yes 2 XNo Director Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 803 Coxswain Ct., #309 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: W.W.II Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IBM Sales Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Schilling Ivan W. Sterling ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 803 Coxswain Ct, #309, Annapolis, MD 21401 Eleanor Jane Sterling/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation 5 Other (Specify)

21. Signature of Street Service Licensee 9/13/08 Edgewater, MD Kalas Crematory George P. Kalas Funeral Home 22. Name and Address of Facility 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 40 Year Physician /Medical r as a consequence of) Examiner nemt eur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the 23d. Date of delivery use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 / No 2 No 1 Yes certificate 1 □Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 | Yes 2 | No Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death After 5 Pending investigation Hospitai or Attending 1 A Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide 1 Legertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner systed. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier deat completed cause 31. Date filed (Month, Day, Year) State SEP 15 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 825 AM **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5257 FERRY BRANCH LANE ANNE ARUNDEL LOTHIAN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 7, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min. NEW YORK 79 085-24-4022 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 ☐ Yes 2 No Director ANNE ARUNDEL LOTHIAN MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20711 UNITED STATES 5257 FERRY BRANCH LANE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, Item Cara Exaninist one. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Completed by Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNITED STATES COVERNMENT PERSONNEL SPECIALIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM MAURICE COSTELLOE AGNES HAMMER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA SCHAEFER GREGG/DAUGHTER 5257 FERRY BRANCH LANE, LOTHIAN, MARYLAND 20711 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of SEPTEMBER 18, Date CHECTENHAM VETERANS CEMETERY 1 Burial 2 ☐ Cremation 3 Removal from State CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CREMATION AND FUNERAL CARI ROAD, ANNAPOLIS, MARYLAND HELFENBEIN AND NEWNAM ARE, P.A., 814 BESTGATE 21. Signature of Funeral Service Licensee Will ErBorn M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Month disease or condition resulting in death) /Medical Due to (or as a conse wance of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or Injury Due to (or as a consequence of): Physician/Medical Examiner resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 2 2 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1☐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

pital or Attending Physician: The law requires that the death certificate be executed ours after death.

leral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760. Division of Vital Records,

death with the Maryland

Baltimore, Maryland 21215-0036

ral", or items 23a or 28a-f shov Examiner wust be mutified at

28a-f shov

Hospital of the Hours a To the Hospital within 24 hours a To the Funeral I

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

SEP 1 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reistrar's Signature

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

			For State Registrar	State of Ma	ryland / Dep	artment of I			000	0 01077
			Registrar 1. Decedent's Name (First, Middle, Las	st)		- Illicale of	Dealli	2. Date of Deat		3. Time of Death
*	Physici /Medic		Joseph E. Shafran					9/11/	2008 Ye	2015 M
1	Examir	er	4a. Facility Name (If not institution, give Anne Arundel Medie				or Location of Deat polis	h	4c. County of D	Death Arundel
	Funeral		Social Security Number 6. S		(In yrs. last birthday		-		9.	Birthplace (State or Foreign
dq	Director		Usual Residence of Decedent		0.1			3/10/1	721	TA
arvland	show	L.	10a. State 10b. County	. 1 . 1	10c. City, Town or I					10d. Inside City Limits
the M	28a-f	ecto	MD Anne Aru	maer	Annapo	10f. Zip Code		1	0g. Citizen of What	1 Yes 2 No
h with	3a or st be r	al Dii	1972 Scotts Crossi	ing Way			1401		USA	oddiny.
5-0036 72 hours after death with the Marvland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married Amarried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1		. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 1210	oan, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
5-00 2-00	atura ical E		15. Decedent's Ed	lucation	16a. Dec	edent's Usual Occu	pation	rking	16b. Kind of Busine	ess/Industry
21215-0036 d within 72 hours aff	ne. han "r e Med	Completed	(Specify only highest grades) Elementary/Secondary (0-12)	College (1-4or 5-	⊦) life.	DO NOT use retire	ed)	rking	W- 12 - D-	7
d 2	Hygie ther t		17. Father's Name (First, Middle, Last)	4	Cons	sultant	18. Mother's Nar	me (First, Middle, I	Media Re	lations
Maryland	Aental rked c	To Be	Louis Shafran				Mollie	Friedman	n	
lary 2 sho	is ma is ma rauma		19a. Informant's Name/Relationship (7		1.0	ling Address (Stree				
6, 7	Health em 27 ther t	1	Shirley J. Shafra 20a. Method of Disposition	ın	20b. Place of Dist	Scotts Consisting (Name of	i		polis, MD 20c. Location - City	
mor	ent of nt: If it ry or o		12©28Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery, ci	ematory or other pla 1111ah Cer	' i			or Township, NJ
Baltimore,	portal portal y inju		21. Signature of Funeral Service Licen		7	22. Name and Addre				
a			23a. Part1. Enter the grease, or comp shock, or heart failure. List only	11/3	1	2 Ridgely	Ave. A	nnapolis,	MD 2140	1 Approximate
E	nysician (Medical xaminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cardio	a consequence of):					Inferval Between Onset and Death
Box 68760, eath certificate be executed	ed by the attending physician and detached for use as the burial-transit	by Physician/Medical E	d						23d. Date of	delivery Day Year
P.O.	y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time or death 5	Other (specify) _				
	been signed b	ed by Pi	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.			te to the cause of death? Probably 4 Unknown
_	(0 ==	Completed						24a. Was a autops perforr 1□ Yes	ned? deat	e autopsy findings available to completion of cause of h? Yes 2 \sumbder No
or Vita Physiclan:	is certificate ha director, page	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only on	e)	
OF Phys	er this grain dir	5	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	y 28b. Time	SIII SU DON		lome 5 ☐ Reside	ence 6 Other (Specify)
Vision	ath. r: Afte e fune	ation	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		rk?]Yes 2 □ No			
Division or all or Attending Phys	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injurbuilding, etc.	ry · At home, farm, s . (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Number on, State)	r Rural Route Number,
Div To the Hospital or	Funer Funer tely fill	Medical (29a. Certifier (Check only one) Certifying Physical Example 1 Cert	ysician: To the best on the basis of	examination and/or	ath occurred at the t investigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time, d	ause(s) and manne late and place, and	er as stated. due to the cause(s)
To the	within 2 To the complet	Med	29b. Signature and title of certifier	and manner stat	iea.	29c. Licen	se number	2	9d. Date signed (N	Ionth, Day, Year)
	> - 0		> Steph	(DO 1	np	De	5851	0	09/1	1/08
_	0.1-		01	complete cause of de	eath (Item 23a) (Type		001 W-32-	o1 Dani-	A	olia MD 21/01
	Sta	tę	31. Date filed (Month, Day, Year)		r's Signature	20	JUI Medic	al rarkwa	ay Annap	olis, MD 21401
	Registr		SEP 1.5	2008	1.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. **Physician** Stinson 2008 10 PM averne /Medical Ac. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton ambridge Dorchester Street Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours -56-823 -5 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ms 23a or 28a-f show must be notified at 1 √Yes 2 No Funeral Director Dorchester 10g. Citizen of What Country? 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Me lical Examiner must be not the content traumatic event, the Me lical Examiner must be not the content traumatic event, the Me lical Examiner must be not the content to the con U S A nton 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Industry ine Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leon Fred Johnson ပ naton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Cambridge, MD. 21613
Date 20c. Location - City or Town, State 504 Clinton Elois Martin permit. Pages 1 au
Department of Hea
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9/20/08 Beckwith Cemetery Cambridge 22. Name and Address of Facility Home, P.A. Henry Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Farl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smoothers are all the control of the control MD.21613 Approximate Interval Between Onset and Death Immediate Cause (Final Metaltatic Adenocarcióne Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner Due to for sele consequence off any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hreet-e 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 2 - No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier tocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 47924 9-16-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE MD 216/2

Registrar DHMH 17 Rev 1/2001

State

THANWY

2008

31. Date filed (Month, Day Year)

503

32. Registrar's Signature

BYRN

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** [™]09/14/2008 1:33 p M Glory Williams Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 301 71st Avenue Seat Pleasant 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours 1 □ M 2 3 F 249-86-3096 Director 61 July 26, 1947 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1

Yes 2□No Prince George's Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 71st Avenue 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 21√2 No Specify: Black <u>Ş</u> 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home maker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Cephus Williams Evelyn Irene Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Thomas/son 5707 Legation Court, New Carrollton MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Riverdale Crematory 9/16/2008 Riverdale, MD 22. Name and Address of Facility J.B. Jenkins Funeral Home re of Funeral Service Licens 7474 Landover Road, Landover, MD 20785 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Non Hodgkins Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 ♣ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy of Vital 2X No 1 □Yes certific director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SXXResidence 6 Other (Specify) 1 Yes 2√No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 ☐ Pending investigation ours after death.

eral Director: Af
filled in by the fur 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rand O.Well D23743 September 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weitz 7525 Greenway Court Drive, Greenbelt, MD 20770 31. Date filed (Month, Day, Year) SEP 1 7 2008 32. Registrar's Signatu State Registrar

8-07224 aniel Thrashe	r	Please Type or Print in Black Indelible State of Maryland / Department amend #5 Per FH G882e3462460			200	8 312
Physic ledical Exam		Decedent's Name (First, Middle,Last) Daniel Jeffre Thrasher		2. Date of Death Month D September 2	Day Year 22, 2008	3. Time of Death 1020 hrs
		4a. Facility Name (if not institution, give street and number) Suburban Hospital	4b. City, Town, or Location of De Bethesda	eathr	4c. County of Death .Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216-22-8710 215-23-2871 Usual Residence of Decedent	If Under 1 Year If Under 24 Months Days Hours	Min. Sept. 1	MM/DD/YYYY) 9. Birth Foreign 3,1988 Cou	
. da war		10a. State 10b. County 10c. City, Town or Loc MD Montgomery Gaitherst			-	10d. Inside City Limits 1 Yes 2 X No
with the Maryland ms 23a or 28a-f shnw be notified at once	Director	10e. Street and Number 7643 Elioak Terrace	10f. Zip Code 20879		Citizen of What Coun	•
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Manhell Hygiene. The marked offlow than "matural", or items 23a or 28a-f Shutraumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin?. Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Americ White, etc.	
hours after 'natural'', o	ģ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed) 16a. Decedent Specific Spec	Yes 2 No specify: ent's Usual Occupation (Give kind most of working life, DO NOT use		Specify: Whi 6b. Kind of Business/Ir	
5-0036. Iled within 72 Hygiene. I other than "r	Completed	Labo	rer		Construct	ion
ore, MD 21215-00. s I and 2 should be filed with of Health and Mental Hygiene If Item 27 is marked other it her traumatic event, the Meg	o Be C	17. Father's Name (First, Middle, Last) Jeffre T. Thrasher 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		rah Brenk		Zin Coute)
Tore, MD 2121 ages I and 2 should be fil nt of Health and Mental I it: If item 27 is marked other traumatic event,	=	Deborah B. Thrasher (Mother) 7643	Elioak Terrace osition (Name of cemetery,	, Gaithers		0879
MOre Pages 1 nent of H ant: If it		1 Burial 2 X Cremation 3 Removal from State Crematory or Met 4 Donation 5 Other Specify:	other place) ropolitan	eptember	Alexandria	
Balti permit. Departi Importi			O E. Deer Park	Drive, Gai	thersburg,	Approximate Interval
Medical xaminer		relate use (Final disease or condition resulting in death) a. Narcotic intoxicati Due to (or as a consequence of):	on			Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate Cause Frace Uncorlying Cause	- Let 12			
executed un and ul - transit	cal Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
Ox 68760, cath certificate be executed attending physician and for use as the burial - transit	Medica	IF FEMALE: 23c. If yes, outcome of pregnancy	,perME, g884 10	/15/08 TT	23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. The law requires the remertal Director: After this certificate has been signed by the attending physiciar upletely filled in by the funeral director, page 2 should be detached for use as the buris	Physician/Medi	past 12 months?	Fetal death 3 Ectopic pre	egnancy	Month D	lay Year
s, P.O. nires that the signed by t	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to t	the cause of death? ably 4 Unknown
of Vital Records, g Physician: The law require the certificate has been sineral director, page 2 should b	Completed			24a. Was an autopsy perform	prior to co	topsy findings available ompletion of cause of s
F Vital Rec Physician: The I r this certificate and director, page	To Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatie		ursing Home 5 Re	esidence 6 Other	
ivision of or Attending Plater death. Director: After din by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury (Month, Day, Year) Fnd 9.22.08 Fnd 6	:50 pm 1 Yes 2X No	28d. Describe how		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		3 Suicide 6 X Could not be determined (Specify) - At home, farm, st house		Bethesd	e5015 BAtte	ral Route Number, City ery Lane
To the Hospital within 24 hours To the Funeral completely filled	Medical	C(bleek only one) 2 Medical Examiner: On the best of my knowledge, death occore) 2 Medical Examiner: On the basis of examination and/or investig and manner stated. 29b. Signature and title of certifier		ed at the time, date an		e cause(s)
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	DOME	September 23, 20	
		Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltim	ore, MD 21201		
Regis	tate trar	31. Date filed (Month, Day, Year) SEP 2 5 2008 Registrar's Signature	de			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 10 2008 **Physician** Robert M. Tobin 04:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√ M 2 □ F Months Days Hours 578-60-9922 02/20/1947 Director 61 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1411 West Street 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify: þ If Yes, Give Year or Dates: 1967-69 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) 5+ Elementary/Secondary (0-12) Self Employed Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Edmund Tobin Lena Madeline Grassa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any injury or other traur Kathryn M. Tobin/Wife 1411 West Street, Annapolis, Maryland 21401 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ R
4 ☐ Donation 5 ☐ Othe (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Kalas Crematory 09/12/2008 Edgewater, Marvland 21. Signature Juneral S 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. P. rt1. En . the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock in heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death MYOCARDIAL INFARCTION ACUTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. I signed by the a d be detached f the 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen HYPERCHOLESTEROLEMIA 24b. Were autopsy findings available prior to completion of cause of death? has le 2 s autopsy page ; performed? Yes 2 No this certificate 1 ∐Yes 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M D28281 30. Name and address of perfect who completed cause of death (Item 23a) (Type, Print) D. 9131 Piscataway Rd #600, Clinton, MD 20735 Nelson Benjers m.D.
31. Date filed (Month, Day, Year) 32 State SEP 1 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 10:55AV 2008 temr 4a. Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES ST. THOMAS MORE NURSING HOME HYATTSVILLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Min. XXM 2□F NORTH CAROLINA 12-29-1921 241-14-2328 86 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits WASHINGTON 1 XIYes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20017 1000 JACKSON STREET U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ★★Yes 2☐ If Yes, Give Year or Dates: 1 ☐ Never Married 🏋 Married 2 □ No Specify: BLACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7TH CAB DRIVER CAPITAL TAXICAB CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mc DONALD HENRY WELCH KATTE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARRIE 1000 JACKSON STREET N.E. WASHINGTON, DC 20017 WELCH/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State CEDAR HILL CEMETERY 09-22-2008 SUITLAND, MARYLAND 4 Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility gnatur of Funeral Servi 3005 12th STREET N.E. TWASHINGTON, DC 20017 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscherotic endiovascular Disease enno sease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

use as the burial-tra

physician

attending p for use as

signed by the a

page 2 s

funeral director,

After this

within 24 hours after death

To the Funeral Director:,
completely filled in by the f

law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Attending Physician:

0 Hospital

Department of H Important: If ite any injury or ot once,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or dical Examiner must be r

death with

Pages 1 and 2 should be filed within 72 hours after

of Health and Mental Hygiene. item 27 Is marked other than "natur other traumatic event, the Medical

altimore, Maryland 21215-0036

DC

Director

Funeral

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Completed

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Physician/Medical Examiner

Completed by

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Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Tyes 2 No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetics Millitz Cenebral In Fauction

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Atrial Ab willation

autopsy performed 1∐ Yes 2 No

24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending

2 Accident

(Check only

29a. Certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 01852 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

eansbory Ad Myattooille MD 2018 DE 31. Date filed (Month, Day, Year)

State Registrar

7 2008



DHMH 17 Rev 1/2001

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			For State Registrar	State of N	Maryland	d / Depa <i>Cer</i>	artment e tificate	of He	ealth a Death	and M		giene Reg. No		8	3128	33
	Physici		1. Decedent's Name (First, Middle, Last) Arther William W	allace							2. Date of De Month Sept.	ath		'ear	3. Time of De	
,	/Medic Examin		4a. Facility Name (If not institution, give s	treet and numbe	er)		4b. City, To			f Death		4c	. County of	Death		
	Funeral		11700 Kimberly Woo 5. Social Security Number 6. Sex		Age (In yrs. la	ıst birthday)	Fort If Under 1		_		8. Date of Bir	th	rince		orges ace (State or Fi	oreian
	Director				1	Yrs.	Months [Days	Hours	Min.	Aug. 8	y, Year	37	Count	nessee	0.0.9.1
	and w		Usual Residence of Decedent 10a, State 10b. County		10c. City,	Town or Lo	cation							10	d. Inside City L	∟imits
	Mary a-f sho ified a	ctor	MD Prince Ge	orges	Fort	Wash	ington	l							1 □ Yes 2	No
	vith the	Dire	10e. Street and Number				10f. Zip O					-	S. A.		ry?	
	ns 23e must	Funeral Director	11700 Kimberly Woo	us Lane 12. Was Deceder Armed Forces	nt Ever in U.S	S. 13. V	207 Was Deceder		panic Orio	gin? (Spe	cify Yes or No		14. Race -		an Indian,	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mentall Hygiene. Important: If them 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 □ Never Married Married Widowed 4 □ Divorced	Armed Forces 12 Yes 2 If Yes, Give Year or Dates	No 1 950)	fYes, specify I□Yes 2X		Specify:	, Puèrto I	cify Yes or No Rican, etc.)		Black, Specify:	White, 6		
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2	other other ent, th	Be Co	17. Father's Name (First, Middle, Last)	_ 		syste	IIIS AIIA	$\overline{}$		r's Name	(First, Middle			. 1011	Tecimo	TOEY
yla	ould be Menta arked aric ev	To B	Edward Lee Wallace			,			Parth	nenia	Darne	11				
Na	d 2 sho th and 7 Is m traum		19a. Informant's Name/Relationship (Typ	,							I Route Numb	-			•	07/4
ָט ע	s 1 an f Heali ftem 2 other		Janice Wallace - w 20a. Method of Disposition		20b. Pla		sition (Name natory or othe				ate FO		ocation - Ci		n, MD 2 wn, State	0744
5	Page nent o ant: If ury or		XXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat			ion Ce			9/20/	2008	C1i	nton,	MD		
Dall	permit. Departr Importa any inji		21. Signal ire of Funeral Service Li Mise	MISON	V	4					.1 & Jo , Temp				L Home : 20748	PA
ij	-347		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caus e cause on each	ed the death.	Do not ente	er the mode of	of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betwee Onset and Dea	en
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ď.	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Sue to (or s	зя а сипвацік	area uffr										
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2000	cate be executed physician and the burial-transit	dical E			, , ,											
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	death certifica attending ph	Physician/Med	23b. Was decedent pregnant in the past 12 months?		ne pf pregnan 2 Fetal o at time of dea	death 3	Ectopic preg						23d. Date o Month		ry Day Yea	ār
į	t the d	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		a 5_	Tottler (apec	,,,,y/								
L , CD	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use 1 ☐ Yes 2 ☒										e cause of deal ably 4 ∐Unk			
5	e law requir has been si je 2 should I	Completed									24a. Was		24b. We	re autor	sy findings ava	ailable
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2	endin eath. or: Aft the fun	atio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Injury	M	1 🗆 Y	es 2 🗆 l	No						
Š	or Att after de Direct in by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of i building,	injury - At hon etc. (Specify)	ne, farm, stre	eet, factory, o	office		2	28f. Location (City or To			or Rura	Route Number	r,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1X Certifying Phys 2 Medical Examin	ician: To the bea ier: On the basis and manner:	of examination	rledge, death on and/or inv	occurred at restigation, ir	the time	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s	and mann d place, and	er as st	ated. the cause(s)	
	To the within To the comple	Med	29b. Signature and title of certifier				29c. L	icense	number			29d. Da	te signed (i	Month, I	Day, Year)	
			Lustes	· Do			H	666	665	5		Šŧ	Pt. K	5,20	108	
	7		30. Name and address of person who co	mpleted cause of	f death (Item 2	23a) (Type, I					000 4	n A	10-	7/	/	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	strar's Signat	DHO!	COURT			M	KGU /	ND	201	1/2		
	Registr		SEP 1 7 2008	Cours ,	I P	No. of Lot										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Cert	ificate of	Death			R	leg. No.	9 0	0 0120
Physicia		1. Decedent's Name (First, Middle,L	.ast)					Date of Dea			3. Time of Death
edical Exami	ner	Lamont Be	enson Wil	lliams			s	Month Septemb	er 10, 2008	11	2216 hrs
		4a. Facility Name (if not institution,	the state of the s		b. City, Town, or	Location of			4c. County	of Death	
		Prince Georges Hospita			Cheverly				Prince C	3eorg∈	e's
F		Social Security Number 6.	Sex 7. Age (In yrs. las	st hirthday)	If Under 1 Yea	r If Under	24Hrs 8	Date of Bi	rth (MM/DD/YYYY	/ g Bir	tholace (State or
Funeral Director		F70 02 4646		ot birarday,	Months Day		1.0		,		nuntD.C.
Director		579–92–4646	X M 2 F 35	Yrs.				May I	8, 1973	Col	unt ry)• ••
er .		Usual Residence of Decedent									
any		10a. State 10b. County		Town or Location							10d. Inside City Limits
re thou	ايا	MD Prince	George's Tem	mple Hi	lls						1 X Yes 2 No
Aaryland 28a-f show 1 at once.	윙	10e. Street and Number			10f. Zip Code		_		10g. Citizen of W	hat Cour	ntry?
or 28	Director	3121 28th Park	Wav		20748				U.S.		
th the											
h wii	uneral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		s Decedent of His es, specify Cubar					e - Ameri e, etc.	can Indian, Black,
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after after ner.	by F	3 Widowed 4 Divorc	ced If Yes, Give Year	1	Yes 2 X No	specify:			Specify:		5367
urs,	d b	15. Decedent's Education (Specify	only highest grade completed)		's Usual Occupa				16b. Kind of Bu	usiness/	ndustry ·
72 hc	leted	Elementary/Secondary (0-12)	College (1-4 or 5+)	auring mo	ost of working life	E. DO NO F	use retirea)				
bin 36	ē	12		Ca	terer				Hotel		
5-00 led with	Compl	17. Father's Name (First, Middle, La	ast)			18.Mother's	s Name (Fi	rst, Middle,	Maiden Surname	2)	
15 E E E E	Be	Benson William				Denis	se Da	vis			
112 Idibe	0	19a. Informant's Name/Relationship		19h Mailing	Address (Stree	et and Num	her or Rurs	I Route Nu	mber, City or Tov	vn State	Zin Code)
MD 21215-0036 42 should be filed within 7 th and Mental Hygiene. n 27 is marked other than	ř				,				s, MD 20		, 2.p occo,
and 2 sh ealth an tem 27 i		Denise Jackson	The state of the s					ate	20c. Location		Town State
Baltimore, MD 21215-0036 permit. Pages I and 2 shouldbe filed within 72 hours after death with the Maryland Department of Healant and Mental Hygiente Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 Cremation		rematory or oth	ition (Name of ce ier place)	metery,					
ages and o		4 Donation 5 Other Spec		incoln	Cemeter	, l	9–18	-08	Suitla	nd,	MD
Iti.	14.0	21. Signatur Funeral Service Lig					,	-	Tai		20018
Ball permit Depart Impor		1/1/1/		Bon	nette &	Assoc	c. Fu	neral	Home 25	04 2	20018 28th St., NE
Dhysician	-	23a. Part NEnter the disease or co	emplications that caused the death								Approximate Interval
Physician /Medical		failure. List only one cause on	each line.						,,		Between Onset and
xaminer		Immediate Cause (Final disease	a. Gunshot Wounds (2) of		Left Forearm	1			•		Death
		or condition resulting in death)	Due to (or as a consequence of)):							
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ecords, P.O. Box 68760, he law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - trans	g	UNPENDED	AMENDED								
760, cate be ex physician he burial	n/Medical	UNPENDED	AMENDED								
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Box 687 ne death certific the attending ped for use as the	jan	past 12 months?	1 Live birth Pregnant at time of dea	_ =	tal death 3	Ectopic	pregnancy	/	Month		Day Year
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n of ing Pt After Tuneral	=	27. Manner of Death	28a. Date of Injury	28b. Time of I	njury 28c. Inju	ury at Work			how injury occur	red	
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Division tal or Attendi rs after death. al Director: A	Œ	3 Suicide 6 Could r	not be		or, ractory, conce	20		or Town.			
ing Spi	Certification:	4 Momicide	(Specify) Local Stree	i.			1101	U DIN AHA	Lostia Road, St	_, vvasi	illigion, MD
To the Ho within 24 P To the Fu completely	g	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledg	e, death occur	red at the time, o	late and pla	ice, and du	e to the car	use(s) and manne	r as stat	ted.
To the within 2 To the complet	Medical	one) 2 Medical Exami	ner:On the basis of examination an and manner stated.	id/or investigat	ion, in my opinio	n, death oc	curred at th	ie time, dat	e and place, and	uue to ti	ie cause(s)
FFF5	ž	29b. Signature and title of certifier			29c. Licen	se number			29d. Date sign	ned (Mo	onth, Day, Year)
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D-15)		Pamela E. Southall, MD			1 Penn Stree	et Baltim	ore MD	21201			
1- (-)		·				,, Januari	.0.0, 1010	2.201			
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Regis	100	SFP 1 6 2008	Markey It M								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Property Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician 7:40 P M atherine Ward September 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Bullimore 6. Sex If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗷 F Months Hours 237-46-0164 VIA North Car. Director January 12,1435 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if we made it is not the rectified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1∰Yes 2 No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20010 USA 1369 Irving Street, N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ If Yes, Give Year or Dates: Specify. 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Ruffin Thomas Blount ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1922 Palmer Park Rd., Landover, MD Deborah Reid - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veteran's Cemetery 9/18/2008 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Malignan I neoplasm - metastatia er month /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760. Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. ned by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🖪 No 2 (L) No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 3 🗌 Suicide ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22500 University NOW 32. Registrar's Signa 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Minnie Elizabeth Wilhide /Medical 2008 3:43 A September 14 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 922 Pennsylvania Avenue Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🔀 F Director 218-40-4164 December 20, 1942 | Hagerstown, Maryland Usual Residence of Decedent 10a, State show 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Modical Experiment must be notified 1√1Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any fujury or other traumatic event, the Medical Examiner must be 1 once. 922 Pennsylvania Avenue 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Ellsworth Dickerhoff Catherine Marie Keeney Dickerhoff ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Wilhide, Sr. Husband 922 Pennsylvania Avenue Hagerstown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Memorial Park 09/17/2008 Williamsport, Maryland 21795 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home, 1331 Eastern Blvd., Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s 24a. Was an autopsy 1 ☐Yes 2 ZNO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2√No Hospital: Other: 1 🔲 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001 W

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1 8 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept Peggy Ann Walters 11^{Day} **Physician** 20ď 7:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Dove House Westminster 5. Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□ M 2 🖺 F 218-28-0127 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning to cutting the matter and any injury or other traumatic event, the Medical Evaning to confidence once. 10b. County Carroll 10c. City, Town or Location New Windsor 10d. Inside City Limits 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 US 1624 Nicodemus Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates: White Completed by Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self-employed seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey T. Seymour L. Miller 0da 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Arnold - daughter 930 Winters Church Road, Union Bridge, MD 21791 Sept Date 12 2008 20b. Place of Disposition (Name of cemetery, crematory or other place)
South Carroll Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of FacilityBurrier-Queen Funeral Home 1212 W. Old Liberty Road, Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lews disease or condition resulting in death) /Medical

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

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hysician/Medical Exa	Sequentially list conditions, if any mode, to in modete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
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	Part II. Other significant conditions	acco use contribute to the cause of death?								
					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of			
Be (25. Was case referred to medical	ath (Check only one)								
0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nursing Home 5 Residence 6 Other (Specify) Nursing Home 5 Residence 6 Other (Specify) Nursing Home 5 Residence 6 Other (Specify) Nursing Home 5 Residence 6 Other (Specify) Nursing Home 5 Residence 6 Other (Specify) Nursing Home 5 Nursin								
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Medical Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	se(s) and manner a and place, and du	s stated. e to the cause(s)							
Me	29b. Signature and title of certifier	1 - 1 0 1	29c. License number				th, Day, Year)			
	Dom/ Melus 1005994									

State

Registrar

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Paul Francis Wooden, Sr. 10, 2008 3:00 P September 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Blakehurst Life Care Community Baltimore County Towson If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months 1 € M 2 □ F 92 220-05-9365 2/09/1916 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐No Baltimore Towson 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1055 W. Joppa Road Apt. 704 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Tyes 2 No 1941 — If Yes, Give Year or Dates: 1945 Black, White, etc. 1 Never Married 22 Married 1 ☐Yes 2 ☐ No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant/Attorney Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lois Benson Ernest Elmer Wooden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type. Print) 4800 Cliff Sullivan Rd., Reisterstown, Paul F. Wooden, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/12/2008 Hampstead, Md. Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee 934 S. Main St., Hampstead, Md. Lemmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) netastatic colon cance 12920 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Stroke 24a. Was an performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2∐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifica

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

Funeral

Director

should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event the Mental and injury or other traumatic event the Mental

Physician

/Medical

Examiner

completely To the I within 2 To the I

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier,

Sept. 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6301 N. Charles St Beltomore MD 21212 D. McConnell William

31. Date filed (Month, Day, Year) SEP 1 2 2008 32. Begistrar's Signature

Physician /Medical permit. Pages 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)

Marian E. White

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	4 4 4		ive street and number)	et. I			r Location of Death	•		County of Dear	
	Montgon 5. Social Security		eneral Hosp Sex 7. Age	(In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	Montgon 9. Bir	thplace (State or Foreign
	217-44-745	0	1□M 2⊠F	66	Yrs.	Months Days	Hours Min.	(Month, Di 02/05/1			ountry) rict of Columbi
	Usual Residence	Y		10a Citu	Town or Lo	antion					10d. Inside City Limits
5	10a. State Maryland	10b. County Montgon	erv		Town or Lo						1 ☐ Yes 2X No
	10e. Street and Nu		iery		- opi	10f. Zip Code			10a, Citiz	en of What Co	ountry?
		crest Rd. #	LL11			20906			U.S.A.		
	11. Marital Status		12. Was Decedent E	ver in U.S.	13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No	o- 1-	4. Race - Ame	
	1 🛚 Never Mar	ried 2 Married	Armed Forces? 1 Tes 2 N If Yes, Give	0		iyes, specily Cuba i∐Yes 2∐ANo	Specify:	nican, etc.)		Black, White Specify: (_{e, etc.} Caucasian
	3 🗆 Widowed	Advis dis-	Year or Dates:							op cony,	
-	(Spe	15. Decedent's E cify only highest g	Education rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worki	ing	16b, Kin	d of Business	Industry
1	Elementary/Sec	ondary (0-12)	College (1-4or 5-	+)	<i></i> 0. E	Clerk	•/			Federal	Government
ı		(First, Middle, Las	it)		-		18. Mother's Name	e (First, Middle	, Maiden S	Surname)	
I	Max White						Sonia Bro	dsky			
į	19a. Informant's N	lame/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or Rura	al Route Numb	er, City or	Town, State, .	Zip Code)
	Mildred W	hite- siste	er in Law				d Blvd. Sil	ver Spri	ng, MD	20906	#106
	20a. Method of Dis		☐ Removal from State	20b. Pla	ce of Dispo netery, cren	sition (Name of natory or other plac	ce)	Date	20c. Loc	cation - City or	Town, State
		5 ☐ Other (Spec		B'Na:		1 Cemetery		4/2008		n Hill, 1	
	21. Signature of F	uperal Service Lice	ensee		22		ss of Facility Hind Hampshire A				
		Lines					•				
	shock, or he	art failure. List only	nplications that caused y one cause on each line	the death. e.	Do not ent	er the mode of dyli	ig, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Immediate Cause disease or conditi resulting in death	on	a. Squ	iamel	5 C	ell pare	Tid glan	d ca	ncer		8days
			Due to (or a la	a conseque	ence of):	an ever)				8 days
Se wentially list conditions If any, leading to immediate Due to (or as a consequence of):								_			0 4443
Cause (Disease or injury that initiated events c.						·					
	resulting in death)	Last	Due to (or as a	conseque	nce of):						
4			d								
1											
2000	IF FEMALE:		VARIATION NAV							3d. Date of de	
	IF FEMALE: 23b. Was deceded in the past 1:		23c. If yes, outcome of	2 🗌 Fetal c	death 3	Ectopic pregnanc	y		2		
	23b. Was deceded in the past 12 1 Yes 2	months?		2 🗌 Fetal c	death 3	Ectopic pregnanc Other (specify) _	у		2:	Month	elivery Day Year
	23b. Was deceded in the past 1: 1 Yes 2, 9 Unknow	Q months?	1 ☐ Live birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal of time of dea	death 3 ath 5 ath	Other (specify) _		23e. Did		Month	
	23b. Was deceded in the past 1: 1 Yes 2, 9 Unknow	Q months?	1 ☐ Live birth : 4 ☐ Pregnant at	2 Fetal of time of dea	death 3 ath 5 ath	Other (specify) _			tobacco us	Month se contribute to	Day Year
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	23b. Was decede In the past 1: 1 □ Yes 2, 9 □ Unknow Part II. Other sign	Rymonths?	1 ☐ Live birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal of time of dea	death 3 ath 5 ath	Other (specify) _	en in Part I.	1 ☐ 24a. Was auto perfo 1 ☐ Yes	tobacco us Yes 2	Month se contribute to No 3 P 24b. Were all prior to	Day Year of the cause of death? Probably 4 Unknown utopsy findings available completion of cause of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death

2. Date of Death

September

3. Time of Death

8:05 AM

2008

DHMH

			1 _ State	ryland / Dep	artment of F rtificate of				
			Registrar 1. Decedent's Name (First, Middle, Last)	06		Death	2. Date of Dea	Reg. No. 2	3 2 0 0
A Park	Physicia /Medic		Audrey L. White				Month 09	Day	Year 008 7:00 AM
	Examin	- 8	4a. Facility Name (If not institution, give street and number)		3.	r Location of Death		4c. County	
***	interior in the second		Sacred Heart Nursing Home		Hyattsv			Princ	0
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 X F 7. Age	(In yrs. last birthday, 86 Yrs.) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 02/03/	1922	9. Birthplace (State or Foreign Country) Virginia
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	shov shov	'n	DC	Washing					1 XYes 2 No
	the N 28a-f sotifie	Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code			10g. Citizen of V	What Country?
	with 3a or t be r	₫	749 Newton Place NW		20010)		USA	*
	ms 2;	Funeral	11 Marital Status 12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-		e - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 N If Yes, Give 3 Widowed 4 Divorced Year or Dates:	lo	1 ☐ Yes 2 ☒ No	an', Mexican, Puèrto Specify:	Hican, etc.)		ck, White, etc. ::Black
9	2 hours	pe	15. Decedent's Education	16a. Dece	edent's Usual Occup	pation	. 1	16b. Kind of Bu	usiness/Industry
215	hin 72 In "na Medio	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	`life.	e kind of work done DO NOT use retire	during most of work d)	ting	TT	1
21	d with	Completed	12 3	,	Clerk			Hospi	
Maryland 21215-0036	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam			ie)
Уlа	Men Men Marke Marke	L ₀	Green Spencer			Mary Bet			
Nar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print)	i	ing Address (Street			-	State, Zip Code) 20010
e,	1 and Healt em 2:		Linda White Morman/Daughter 20a. Method of Disposition	20b. Place of Disp	ewton Pla	1	shingto	,	City or Town, State
п	ages int of t: if it		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	Fort Lin	ematory or other pla	and the second second	3/2008		od, Maryland
Baltimore,	artme ortani Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	1					Home, Inc.
Ba	Dep Imp any onc		Del Mars 2	<i>()</i>	217 Ninth				-
М	- 4		23a. Part Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final	ensive Car	diovascul	ar Diseas	se		Onset and Death
Į,	/Medical		regulting in death)	a consequence of):	410,48641				
H.	Examiner	L	Sequentially list conditions	ry Atheros	clerotic	Disease			
	ed sit	Examiner	ii any, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of).					
	xecut and al-tran	xan	that initiated events resulting in death) Last Due to (or as a	a consequence of):					
8760,	cate be executed physician and the burial-transit	dical E							
89	ificate g phy: as the	edic	u						
Вох	death certific e attending p id for use as	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		□Ectopic pregnanc			23d. Da	te of delivery
Э.	0 0 0	Physician/Me	1 ☐ Yes 2 No 4 ☐ Pregnant at		Other (specify)	у		Mo	onth Day Year
P.0.	that the de	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but	it not reculting in the	underlying course giv	on in Port I	23e Did to	nhacco use cont	tribute to the cause of death?
Records,	6 50	Completed by	Progressive Cognitive Deci	-	underlying cause gr	en in raici.	1 🗆 1		3 ☐ Probably 4 Unknown
COL	w require been sign	lete					24a. Was	an 24b.	Were autopsy findings available
	The law cate has b	dwc						rined?	prior to completion of cause of death?
ta		Be Co	25. Was case referred to medical			26. Place of Deat	1 Yes th (Check only o	/ 	1 ☐ Yes 2 No
>	ys dir	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	ent 3 DOA Oth	or:		dence 6 Oth	ner (Specify)
0 0	<u>a</u> ± e		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injur (Month, Day		of 28c. Inju Wo	ry at rk?	28d. Describe	how injury occur	red
Sio	Attending r death. ector: After y the fune	catic	2 Accident investigation			Yes 2 □ No			
Division or Vital	l or Att after de Direct I in by i	Certification:	4 ☐ Homicide determined 28e. Place of inju	iry - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (8 City or Tox	Street and Numb vn, State)	ber or Rural Route Number,
_	spital ours a neral I		29a. Certifier Certifying Physician: To the best of	of my knowledge, dea	ath occurred at the ti	me, date and place	, and due to the	cause(s) and ma	anner as stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical	(Check only 2 ☐ Medical Examiner: On the basis of and manner sta						
	with Tot	Σ	29b. Signature and title of certifier	>	29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)
	5				D0051	122	S	Septembe	r 15th, 2008
			30. Name and address of person who completed cause of de		,	_ NT TT T	J1. 4 ·	D 0	20017
Ø.	Sta	te	Esmerando O. Juanitez, MD. 31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	num Stree	L, N.E. V	vasningt	on, D.C	20017
	Registi		SEP 16 2008	H A	ant a				

DHMH 17 Rev 1/2001

P.O. Box 68760 Division or Vital Records, al or Attending P s after death. Il Director: After t within 24 hours a To the Funeral

State Registrar

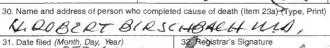
Medical

31. Date filed (Month, Day, Year) SEP 16 16

29a. Certifier

(Check only one)

29b. Signature and title of certifier



GALTHERSBURE,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

004-115

201 RUSSELL

29d. Date signed (Month, Day, Year)

MI 20877

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Dav **Physician** Gerda Saxdal Williams Sept 2008 7:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 01/18/1918 9. Birthplace (State or Foreign Country)
Denmark 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 122-22-7589 90 Months Days Hours Min 1 □ M 2 🛛 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If "Medical Exagration and the most and the analysis of the straumatic event, If "Medical Exagration and the most analysis of the straumatic event, If "Medical Exagration and the most analysis of the straumatic event, If "Medical Exagration and the straumatic event, If "Medical Exagration and the straumatic event, If "Medical Exagration and the straumatic event, If "Medical Exagration and the straumatic event, If "Medical Exagration and the straumatic event, If "Medical Exagration and the straumatic event, If "Medical Exagration and the straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event, If "Medical Exagration and straumatic event 1 Ves 2 □ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 80 East Street 21401 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1X Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: 1943-45 Specify. Specify: White ģ 3 N Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peder Saxdal Johanne Ledet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha J. Chalmers/Daughter 80 East Street, Annapolis, Maryland 21401 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 09/11/2008 | Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Luc Part1. En ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death median Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and Due to (or as a consequence of): burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical 88 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 1 Yes 2 No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₽ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director; A completely filled in by the ft death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the cont Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, 14300 Gallant Fox Lane, Suite 222, Bowie, Maryland 20715 gistrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 2 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 JOHN J. YOUNG 9:25 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Months Days Hours Min. 1 X M 2 □ F 69 221-24-7846 4-19-1939 PENNSÝLVANIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No **DELAWARE** SUSSEX FENWICK ISLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 WEST BAYARD STREET 19944 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify: WHITE Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) PAPER PRODUCT Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH FRANCIS YOUNG ELIZABETH LAUGINIGER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. SUZANNE YOUNG/WIFE 24 WEST BAYARD ST, FENWICK ISLAND, DE. 19944 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State MELSONS CREMATORY 9-16-08 FRANKFORD, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funal Service MELSON FUNERAL SERVICES, LTD. esus WEST AVENUE, OCEAN VIEW, DE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ATHEROSCLEROTIC HEART DISEASE YEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERLIPIDEMIA 1 ☐ Yes 2 ☐ No 3 1 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

death with

should be filed within 72 hours after

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permit. Pages 1 an. Department of Healt Important: if item 27 any injury or other tra-

altimore, Maryland 21215-0036

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, in a Modical Examiner must be realthed at

Examine Physician/Medical ۾ Completed

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Certification: To

Medical

burial-transit and attending physician as the for use ned by the a detached f cate has been signed page 2 should be det certificate has funeral director,

After this

24 hours after death. Funeral Director: A

within 2.

BA 10

filled in by the

completely

Hospital or Attending

law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭XNo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DE

C1-0006795

9-17-2008

Ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISTINE GRIFFIN, MD. 33195 LIGHTHOUSE RD, UNIT 6, SELBYVILLE, DE. 19975 31. Date filed (Month, Day, Year)

State Registrar

SEP 17 2008 32/Registrar's Signature

State of Maryland / Department of Health and Mental Hygien P 1 1 8 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:05 PM^M September 28, 2008 Maryann Abbe /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Manor Care Chevy Chase Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 71 Yrs. Director 373-38-5310 02/09/1937 MI Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If I tam 27 is marked other than "natural" ~ ... any injury or other traumatic avera 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD Montgomery Germantown 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 19918 Sweetgum Circle Apt. #11 20874-United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဤ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Nursing Home Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Furton Julia Clark ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ayla Meurer/Sister 14812 Ridge Oak dr. Boyds, MD 20841-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct 2 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed. use as the burial-transit that initiated events Due to (or as a consequence of): nding physician and resulting in death) Last Box 68760. Physician/Medical Arterial Fibrillation IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2□ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending naral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funaral Dire o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-20276 9/29/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Blvd. Kirti Vohra M.D. Bethesda, MD 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, La, 3. Time of Death Month Year **Physician** ant 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner sozita If Under 1 Year If Under 24 Hrs. 9. Birthplace (State **Funeral** Days Min. 1**X** M 2□ F Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mentat Hygiene. 10a State 10b. County City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or items 23e or 28e-1 show eny injury or other traumatic event 1 Yes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? e: Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Second (0-12) College (1-4or 5+) pratoR 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) In Known 19b. Mailing Address (Street and Number or 3413 Keisterstown 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R

4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Ommunity. /Medical Due to (or as a consequence of): Examiner Q7515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner (or as a consequence of). The law requires that the death certificate be executed use as the burial-transit the attending physician and K hed for use as the burial-transi nemia resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2X No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 1 🖍 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 24 hours after death e Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD ol death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause

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31. Date liled (Month, Day, Year)

32. Registrar's Signature

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State of Maryland / Department of Healt

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th and Mental Hygiene	2	N	0.8	31	20	36
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Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER HELEN S. ALFORD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8201 16TH STREET #309 SILVER SPRING Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 577-46-1263 Yrs Director SEP. 7, Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f show the Wedical Exercitor coust be notified at Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8201 16TH STREET #309 20910 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ∑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) of Health and Mental Hygier them 27 is marked other the other traumatic event, the ANALYST 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental NETTIE ROGERS ပ JEREMIAH STALLINGS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other trong. LISA M. ALFORD / DAUGHTER 60 ERIN LANE EAST SETAUKET, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL 109-26-2008 21. Signature 22. Name and Address of Facility DONALD R. GRAY 4308 SUITLAND ROAD Part 1 Enter the disease, shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part 1 mediate Cause (Final Immediate Cause (F disease or condition resulting in death) **Physician** BREAST CARCINOMA /Medical Due to (or as a consequence of) **Examiner** METASTATIC BREAST CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ling physician and sas the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: for use yes, outcome of pregnancy

Live birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🎇 No Pregnant at time of death signed by the a Division of Vital Records, P.O. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 24a. Was an has page 2 s performed certificate After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year) SEPTEMBER 24, 2008

State Registrar

DHMH 17 Rev 1/2001

Day 21. 2008

12:45 PM 4c. County of Death

MONTGOMERY Birthplace (State or Foreign Country)

3. Time of Death

1934 NC

10d. Inside City Limits 1 Yes 2 No

USA

Black, White, etc. Specify: BLACK

14 Bace - American Indian.

FEDERAL GOVERNMENT

18. Mother's Name (First, Middle, Maiden Surname)

NY 11733 20c. Location - City or Town, State

SUITLAND, MD MARSHALL'S FUNERAL HOME OF MD

SUITLAND, MD 20746 Approximate Interval Between Onset and Death

23d. Date of delivery Month

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

1∐Yes 2∭ZNo

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Year

3 YRS

28d. Describe how injury occurred

20706

32. Registrar's Signature

D0043180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN BLEDSOE

Year) 0 1

2008

7404 EXECUTIVE PLACE #501

LANHAM, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008

			1 - For State Registrar	State of mar	-	Certificate of	Death	-	Reg. No.	008	312	291
	Physici	an	1. Decedent's Name (First, Middle, La	· '				2. Date of De Month	ath Day	Year	3. Time of D	eath
	/Medic		Dorothy Lena						-2008		3:30P	M
	Examin	er	4a. Facility Name (If not institution, gi				or Location of Death			ty of Death		
	Funeral		7 Fencerow Cou 5. Social Security Number 6.		In yrs. last birtho	day) If Under 1 Yea		8. Date of Bir	th	alto. 9. Birthp	place (State or I	Foreign
	Director		016-22-1185	1□M 2XDF 83	3 Yr	s. Months Day	Hours Min.	7-18-		Bostor		
	pu ,	1	Usual Residence of Decedent		0c. City, Town o						0d. Inside City	Limito
	aryla shov ad at	5	Md. Balto		uc. City, Town c		ngham			"	1 ☐ Yes 2	
	he M 28a-f otifie	Director	10e. Street and Number	•		10f. Zip Code			10g. Citizen of	f Mile at Cours		
	with with the result of the re	ä									uy:	
	Jeath	Funeral	7 Fencerow Cour 11. Marital Status	12. Was Decedent Eve	er in U.S.		236 Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No	USA 14. Re	ace - Americ	an Indian,	
9	or ite	Ē	1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates:		If Yes, specify Cu		Rican, etc.)		ack, White, e		
200	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the "scient Evaniner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Spec		nite	
215-0036	"nati	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. D	ecedent's Usual Occ Give kind of work don	upation e during most of work ed)	ring	16b. Kind of I New En	Business/Ind gland	tustry Teleph	one &
7.	withir iene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		n. Assista			Telegr			
Ö	filed Hyg other ent,	Be C	17. Father's Name (First, Middle, Las		ACIII.LI	1. ASSISLA	18. Mother's Nam	e (First, Middle	, Maiden Surna	ıme)		
<u>a</u>	Aenta Aenta rked tic ev	To B	John B. Atkins				Elena	M. Com	nier			
a	and N	-10	19a. Informant's Name/Relationship	(Type. Print)	19b. N	Mailing Address (Stree	et and Number or Ru	ral Route Numb	er, City or Tow	n, State, Zip	Code)	
Σ.	and 2 ealth n 27 i		Joseph Atkins	Nephew			ing Rd. I	Relay, 1				
Baltimore, Maryland 2	jes 1 t of Hi lf iter or oth	-09	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other p	ace)	Date	20c. Location	ı - City or To	wn, State	
Ē	t. Pag tmen tant: jury	19	4 Donation 5 DOther (Speci	ify)	Blue H	ill Cem.	10-7-	1	Massac			
a R	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic enone.		21. Signature of Euneral Service Lice	nsee		22. Name and Add		chimunel				
			23a. Part 1. Enter the disease, or con	polications that caused th	e death Do no		Belair Rd			Mu. Zi		
		S 76	shock, or heart failure. List only	one cause on each line.				or respiratory a	11031,	1	Approximate Interval Betwee Onset and De	en eath
· .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. My o Cow Du to (or as a c	one of the last	intarci	ian				Shou	rs
	Examiner			+1001	orisequence of	infarci	wellitis				Syrs	
	n +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	onsequence of)		0000					
	scuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. atral	Am	llation					Lyrs	
Š,	be exician sourial-	ũ	resulting in death) Last	Due to (or as a c	onsequence of)	:						
68/60 ,	physi physi the t	Medical		d								
×	certif	/Me	IF FEMALE:	23c. If yes, outcome of p	pregnancy				23d D	ate of delive	erv	
Ž P P	death e attel	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ⊠No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)					Day Ye	ar
5	t the	hys	9 🗆 Unknown	9 Unknown								
'n	ss tha gned se det	by P	Part II. Other significant conditions	contributing to death but n	not resulting in th	ne underlying cause g	iven in Part I.	23e. Did 1	tobacco use co	ntribute to th	ie cause of dea	ath?
D D	equire	ed						1 🗆	Yes 2 □ No	3 ☐ Prob	ably 4 XUn	iknown
Hecords,	law r las be	Completed						24a. Was		prior to cor	psy findings av	/ailable use of
E	: The cate h	S							ormed? 2 ZNo	death? 1 □Yes	2 □No	
VII	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat	. /				
5	Phys rathis rathin	£.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outp	allent 3 DOA	ther: 4 Nursing He		dence 6 □0 how injury occu		y)	
0	ding th. : Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Yo	<i>(ear)</i> Inju	ıry W	ork? □Yes 2 □No	250. Describe	now injury occo	11100		
VISION	Atter	ilica	3 Suicide 6 Could not b	28e. Place of Injury	- At home, farm	, street, factory, office	==	28f. Location (Street and Nun	nber or Rura	l Route Numbe	er,
5	safte s afte al Dire	Certification: To	4 Homicide	building, etc. (Ѕреспу)			City or To	wn, State)			Į
	lospit hour unera			hysician: To the best of n miner: On the basis of ex								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one)	and manner stated								
	0 4 kg • 0	-	29b. Signature and title of certifier	m MD			nse number 1584		29d. Date sign	1		000
	12	-	20 N		L /II- 05 : =				Septen	roer,	50,0	000
	1		30. Name and address of person who	completed cause of deat	n (Item 23a) (Ty ムロ いん	rpe, Print)	BALT	Imale	md.	7112	, ,	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	XITIK NO.	DULL	FROLD	iria	d 123		
	Registr	_	UG Q 1 20	08	N. A	raches						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Significanties 21, Year 2008 **Physician** 1:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MILLERSVILLE ANNE ARUNDEL KNOLLWOOD MANOR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2□F 216-52-7678 Director SCOTIONBOR Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Eventing must be notified at Director 1 **(**Yes 2 □ No WASHINGTON IX 10e. Street and Number 2000 2112 GEORGIA Funeral unk | 12. Was Decedent Ever in U.Sunk | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: þ Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trauonce. Genesis Knollwood Manor 899 Cecil Avenue South Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State in/state 4 ☐ Donation _5 X Other (Specify) 21. Signature of Funeral Solice Licenses Remain Solice Made 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 23a. Party. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate one (Final disease or condition resulting in death) Physician WEEKS /Medical Due to (or as a consequence of): Examiner 2 YEARS DISEASE CEREBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š icate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 Wo certificate 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

29b. Signature and title of certifier

MD 9005 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

031136

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Plea amend	se Type or Pring 1 items 19a, State of M	nt in Black b per fh arviand / De	ndelible Ink	Ensure A	All Copies A	re Legible.	
	•	For State Registrar	State St III		ertificate of			g. No. 2 / / / /	2 31200
Physicia	an	1. Decedent's Name (First, Middle	e, Last)	200		· ·	2. Date of Death Month	Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution	n, give street and number)	Door		r Location of Dea	<u>Geptembe</u>	4c. County of Dea	
	ς.	Milford Ma	mor Nurs	11	e Pike	esville		Balt	inole
Funeral Director		5. Social Security Number	6. Sex 7. Ag	e (Hryrs. last birthdi Yrs	Months Days	If Under 24 Hrs Hours Min	(Month, Day,	Year)	rthplace (State or Foreign country)
D		Usual Residence of Decedent 10a. State 10b. County		O1			March i	8, 1927 B	altimore
Maryla -f sho	tor	MD Bo	altimore	10c. City, Town or	Location	ا			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith the	Director	10e. Street and Number	10 1	<i>i</i> 0 1	10f. Zip Code	4	10	g. Citizen of What C	ountry?
eath w	Funeral	11. Marital Status	12. Was Decedent	KoL		1208	Procify Voc or No	USK	}
after d		1 Never Married 2 Marr	Armed Forces?	No No	3. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ▼ 100		to Rican, etc.)	14. Race - Am Black, Whi	te, etc.
hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	160 Da	cedent's Usual Occup			Specify: B	Tack
thin 72 e. an "na Medic	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	St grade completed) College (1-4or 5	(G	ive kind of work done e. DO NOT use retire	during most of wo d)	rking	6b. Kind of Business	
iled wil Hygien ther th	Co	17. Father's Name (First, Middle,		Lau	N Cleri	10. Mathada Na	me (First, Middle, Ma	Pailroad	Chesse Jyst
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Extrainer must be notified at	To Be	Livis A:	Bone			18. Mothers Na	e Mae	Rage Surname)	
2 shou and N is mai		19a. Informant's Name/Relationsl		19b. Ma	ailing Address (Street	and Number or R	ural Route Number	City or Town, State,	Zip Code)
1 and Health tem 27			Weyn Sen	20b. Place of Dis	2 Card	endel		Oc. Location - City of	Md 21044
Pages nent of I int: If Ite		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from State	Metro	rematory or other place	ce) a/	30/08 7	Baltime	- 11
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan D partment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Extrainer must be notified at order.		21. Signature of Smeral Service	Licensee	7	22. Name and Addre	s of Facility	owell Fi	meral	Horse
E0 2 6 0		23a. Part 1. Enter the disease, or	complications that caused	the death Do not	4600 Lib	erty He	hts Ave,	Balto.	Approximate
Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each li	ne.			OVASC		Interval Between Onset and Death
/Medical Examiner		resulting in death)	a	a consequence of):			D	(7FV7)	<u> </u>
A	je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of).					1
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bur be	<u></u>	rooding in death, Last		a consequence of):					
rtificate t ng physic as the b	Physician/Medic	IF FEMALE:	d						
eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnanc	y		23d. Date of de	elivery Day Year
at the de by the	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (specify) _			Wollin	Day Tear
res the rigner igner de d	2	Part II. Other significant condition			106 20				to the cause of death?
v requi	Completed	12 12-1C 1C	-(N20N	7 7	176V	> &		2 □ No 3 □ F	1
The lav	dwo					 :	24a. Was an autopsy performs	prior to death?	
	Be C	25. Was case referred to medical examiner?				26. Place of De	1 □ Yes 2 ath (Check only one)	No 1 ☐ Ye	s 2 LyNo
Physi r this c ral dire	္	1 Yes 2 No 27. Manner of D ath	Hospital: 1 Inpatie	ent 2 ER/Outparry 28b. Time		4 Nursing I	Home 5 ☐ Residen		ecify)
ath. r; Afte	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Da	y, Year) Injur	y Wor	k? Yes 2 □ No	28d. Describe how	rinjury occurred	
or Atte	iii	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Fi State)	lural Route Number,
spital nours a neral C		29a. Certifier Certifyin	g Physician: To the best	of my knowledge, de	eath occurred at the ti	me, date and place	e, and due to the cau	use(s) and manner a	as stated
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical I	Examiner: On the basis of and manner sta	r examination and/o	investigation, in my o	ppinion, death occ	urred at the time, dat	e and place, and du	e to the cause(s)
To with	2	29b. Signature and title of certifier	-O.B.	Phin	29c. Licens	e number	290	d. Date signed (Mon	th, Daly, Year)
		30. Name and address of person v	who completed cause of d	eath (Item 23a) (Tvo	e, Print)	1416	30	1/2	1 0 5
5		6717	PARIC	HEIG	1475	Bus	NUE	_ 2	1215-
Stat Registra	_	31. Date filed (Month, Day, Year) OCT 0 1	2008 32 Registra	E.	beste				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:30PM **Physician** /Medical Facility Name (If not institution, give street and number) ty, Town, or Location of Death Examiner llstown 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months Director 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tre the discillate internuel to a colling a 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f Zin Code 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 o 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life, DO NOT use retired) dary (0-12) College (1-4or 5+) pment and Mental Hygier is marked other th Middle, Last) Be ပ of Health a Place of Dispositi centetery, cremat 20a. Method of Disposition ö ■ Burial 2 ☐ Cremation 3 Removal from State Department or Important: If any injury or once. 4 Donation 5 ☐ Other (Specify) 21. Signat re of Funeral Service Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Brain Cancor disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 2. No 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) HOSPILE Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After t 1 🗹 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2

0 State 29b. Signature and title of certifier

30. Name and address of

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

person who completed cause of death (Item 23a) (Type, Print)

25

Registrar's Signature

29c. License number

STRUCT

144593

REISTERSTOWN

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	otate of mai	,	ertificate of		Reg. N	10.2008	31301
	Physicia	an	1. Decedent's Name (First, Middle	- 17	1_			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Betty Je 4a. Facilify Name (If not institution		K	4h City Town o	r Location of Death	September	29 2008 4c. County of Death	7:50 P M
	Examin	er	Manor Care Nur				onsville		Baltimor	æ
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	place (State or Foreign
	Director		229-56-7761	1□M 2 X F 6	Yrs.			03/01/194	4 North	n Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or	Location			1	0d. Inside City Limits
:	Mary a-f sh	햣	Maryland H	loward	Ellio	ott City				1 □Yes 2 XNo
	or 28	Directo	10e. Street and Number			10f. Zip Code			Citizen of What Cour	ntry?
	ath wi	rall	8966 Chapel Av				043		U.S.A.	an Indian
	items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Was Decedent Ev Armed Forces? rried 1 ☐ Yes 2 █️No		 Was Decedent of F If Yes, specify Cubin 		o Rican, etc.)	Black, White,	etc.
9500-912	thin 72 bours after death with the Maryland e. "ma'matural", or items 23a or 28a-f show Medical Evans are roust by routified at	þ	3 W Vidowed 4 □ Divorced	If Yes, Give		1 □ Yes 2 XNo	Specify:		Specify: Bla	ick
2-C	72 ho	Completed	15. Deceder	nt's Education est grade completed)	16a. De	cedent's Usual Occup ve kind of work done e. DO NOT use retired	oation during most of work	l 16b.	. Kind of Business/In	dustry
[2]	filed within 72 Hygiene. other than "nal ent, in Medic	du	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retire: ness Admir			Medical	
2	be filed v ntal Hygie id other i event, in		17. Father's Name (First, Middle,	_	Dust	IRESS MUNICI		ne (First, Middle, Maid	len Surname)	
an	be d o	To Be	James Willie Ma	anning Sr.			Hazel M	ae Smith		
Maryland	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relations	ship (Type. Print)	l l	-		ıral Route Number, Cit		
S	and 2 ealth a n 27 is		Tiffany D. Broo	oks / Grand- Daughter	- 8966			cott City,	Maryland Location - City or To	21043
altimore,	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation	3 ☐ Removal from State	cemetery, c	sposition (Name of rematory or other place	^{ce)} 10/0	4/2008	•	
	it. Pa trtmer rrtant: njury		4 ☐ Donation 5 ☐ Other (5		KING ME	morial Pk.		Derrick C	ltimore,	
Ba	permit. Pages 1 and 2 Department of Health s important: If item 27 is any injury or other tra		21. Signature of Furieral Service	Elicensee				e., Baltim		
П			23a. Part 1. Enter the disease, o	or complications that caused to only one cause on each line	the death. Do not					Approximate Interval Between
4	hysician		Immediate Cause (Final disease or condition			E CARDO	6 VASCULA	R DISEA	138	Onset and Death
	/Medical		resulting in death)		consequence of):					
٦	Examiner	<u>.</u>	Sequentially list conditions,	b. Dura to for at a	consequence of):					
W	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	One of force of	corsequence cry					
1	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):					
68760,	ate be hysicia he bu	Medical		d						
∞ ×	ertific ding p	Med	IF FEMALE:	23c. If yes, outcome of	of prognancy				20 d Data of delib	
Вох	eath cer attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	2 ☐ Fetal death	3 ☐ Ectopic pregnand	су		23d. Date of deliver Month	Day Year
o	at the de I by the a tached I	Physician/	1 □ Yes 2 ⊠No 9 □ Unknown	9 Unknown	ano or dodar	o E other (opeony)				
ď.	s that med b e deta	by Pł	Part II. Other significant condit	tions contributing to death but	t not resulting in the	e underlying cause gi	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
īg	w requires that s been signed b should be deta							1 🗀 Yes	2 No 3 Pro	obably 4 Unknown
Records,	law re las be 2 sho	Completed						24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u>~</u>	Physician: The fav this certificate has al director, page 2	Con						performed 1 □ Yes 2		2 🗆 No
VII:	ician certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:		Ot		ath (Check only one)		
0	Phys r this ral dir	년:	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☐ Inpatier	nt 2 ER/Outpa y 28b. Tim	itient 3 DOA	4 IX Nursing F	Home 5 ☐ Residence		ify)
0	nding tth. ; Afte e fune	tion	1 Natural 5 ☐ Pendi		(<i>Year</i>) Inju		rk? ⊡Yes 2 □ No			
Division of Vital	r Atter	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	d not be mined 28e. Place of Inju building, etc.	ry - At home, farm, . <i>(Specify)</i>	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	ital or Irs afte ral Dis	Cer								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to the funeral director.	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the best on al Examiner: On the basis of and manner sta	examination and/o	eath occurred at the for investigation, in my	ume, date and plac opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	to the cause(s)
	To the vithin Fo the comple	Mec	29b. Signature and title of certific			29c. Licen	ise number	29d.	Date signed (Month	, Day, Year)
			1	M.D		200	59107	0	9-30-2	2008
	K		30. Name and address of perso	1	eath (Item 23a) (Ty	pe, Print)				
	5		KALU UM	A 210 Barietra	MANESIN KAN	CENTER	DRIVE	KENITER	Jan M	no 21136
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea.	r) 32. Hegistra	r's Signature	make 1				
	7		OCT 0.1	2008	1788 6885	100				

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		nt in Black Indelible Inl	•	•
	1 - For State of M Registrar	aryland / Department of <i>Certificate of</i>		Reg. No. 2008 31302
Physician /Medical	1. Decedent's Name (First, Middle, Last) Margaret Mark	cs Brown	2. Date of Dea Month	26.30 AM
Examiner	4a. Facility Name (If not institution, give street and number)		or Location of Death	4c. County of Death
Funeral Director	230-38-8724 10M 20-	e (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Birtl	9. Birthplace (State or Foreign Country)
ryland	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits 1 ☐ Tes 2 ☐ No
rith the Mar or 28a-f sl be notified Director	10e. Street and Number	Baltimore 10f. Zip Code		1 Tes 2 No 10g. Citizen of What Country?
death with the Maryland ms 23a or 28a-f show r.must be notified at neral Director	1711 E. Federal St	213	213	U.S.A
or ite	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	If Yes, specify Cu	Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify:
offied within 72 hours If Hygiene. other than "natural", rent, Ith "Ith Crost Ex-	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occ (Give kind of work don	e during most of working	16b. Kind of Business/Industry
filed within 72 hou Hygiene. Sther than "natura ent, in moderal e Completed	Elementary/Secondary (0-12) College (1-4or	5+) Janitor	ial	Bank of Wayerly
ould be file Mental Hy arked oth atic event	17. Father's Name (First, Middle, Last) Cassius Marks		18. Mother's Name (First, Middle,	Maiden Surname)
2 should and M is marl raumati	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street	et and Number or Rural Route Numbe	
s 1 and of Health item 27 other to	20a. Method of Disposition	20b. Place of Disposition (Name of	deral St. Butin	20c. Location - City or Town, State
tt Pa rtmer rtant:	1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Church of All Noction	10.4.2008	Springrove, VA Gréene Funeral Services
Deparation of the control of the con	21. Signature of Funeral Service Licensee	363 4405 %	ess of Facility Vaughn C.	Greene Funeral Services
bysisian	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li Immediate Cause (Final	d the death. Do not enter the mode of d	ving, such as cardiac or respiratory ar	
Physician /Medical Examiner	disease or condition resulting in death) a Due to (or as	a consequence of):	en disease	many years
Je Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):		
be executed sician and purial-transit	Cause (Disease or injury that initiated events c.	a consequence of):		
g cia	d			
The death certificate be exected by the attending physician and etached for use as the burial-train. Physician/Medical Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome	of pregnancy 2 ☐ Fetal death 3 ☐ Ectopic pregna	псу	23d. Date of delivery Month Day Year
by the at ached fo	1 Yes 2 No 9 Unknown 9 Unknown	at time of death 5 Gother (specify)		Month Day rear
The law requires that the death certificate at the has been signed by the attending physiong 2 should be detached for use as the becampleted by Physician/Medica	Part II. Other significant conditions contributing to death to	out not resulting in the underlying cause of block	iven in Part I. 23e. Did to 1 ☐ Y	obacco use contribute to the cause of death?
cate has been s page 2 should	Ly 10 Va trenia		24a. Was a	
ifficate h	25. Was case referred to medical		perfor	rmed? death? 2 ANo 1 □ Yes 2 □ No
mysician this certif al director	examiner? 1 Yes 2 No Hospital: 1 Inpati	ent 2 En/Outpatient 3 DOA	ther: 4 Nursing Home 5 Resid	dence 6 Other (Specify)
ath. r: After e funera	27. Manner of Death 1	ay, Year) Injury W	ury at 28d. Describe h ork? ∐Yes 2 □No	now injury occurred
rial of Attending Price and Director: After 1 led in by the funers Certification:	3 Suicide 6 Could not be determined 28e. Place of Inbuilding, et	ury - At home, farm, street, factory, office ic. (Specify)	28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)
The hospital of Attending Priysician: The law requires that the of within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Medical Certification: To Be Completed by Physic		of my knowledge, death occurred at the of examination and/or investigation, in mated.		
within To th comp	29b. Signature and title of certifier		nse number	29d. Date signed (Month, Day, Year)
. [30. Name and address of person with completed cause of o	death (Item 23a) (Type, Print)	0 0 5 6 5 0 3	September 29, 200 f.
State	31. Date filed (Month, Day, Year) 32(Registr	an 5601 loch rar's Signature	Maver Blod. Ba	ltmon , ND 21239
Registrar	OCT 0 1 2008	rar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26, September 2008 1:50 A M ROBERT MITCHELL BELL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Memorial Hospital Frederick 9. Birthplace (State or Foreign Country)
PA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 25, 7. Age (In yrs last birthday) Social Security Numbe 204–42–2099 Months Hours Days Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Maryland Mt. Airy Carroll 1 Tyes XX No 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 7844 E. Hill Road 21771 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married 1 ☐Yes 2 No Specify If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) self-employed Truck Driver 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Bell, Sr. Grace Seager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7844 E. Hill Road Mt. Airy, MD Margaret Bell Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State South Carroll Crematory Sept. 26 2008 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 23. Name and Address of Facility Burrier - Queen Funeral Home & Crematory, PA 212 W. Old Liberty Road Winfield, MD 21784 21. Signa ure of Funeral Service 1212 W. Old Liberty Road Approximate Interval Between Onset and Death art / Enter the disease, or complications nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shield, or heart failure. List only one cause on each line. Immediate Cause (Final Infortion hour Myocar dial disea e or condition reliting in death) Due to (or as a consequence of): Coranery 18615 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Ye ar 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once.

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedesules at

2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or ite

3altimore, Maryland 21215-0036

the Maryland

death with

/Medical

Director

Funeral

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Completed

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be Certification: To

Medical

State

Registrar

CALDIC	my aga thy				1 ☐ Yes	2 No 3 Probably 4 Unknown
Dialik	45				24a. Was an autopsy perform	prior to completion of cause of
25. Was case referr	ed to medical			26. Place of Dea	ath (Check only one))
examiner? 1 ☐ Yes 2 🗹	40	Hospital: 1 ☐ Inpatient 2 ☐ 1	ER/Outpatient 3 🗆	DOA Other: 4 Nursing H	lome 5 ☐ Resider	nce 6 Other (Specify)
27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	v injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		me, farm, street, fact	ory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
		nysician: To the best of my know miner: On the basis of examinat and manner stated.				use(s) and manner as stated. te and place, and due to the cause(s)
29b. Signature and	title of cortifier			29c. License number	29	d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ninth Street frederick 21701

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2008

BUKI 310

32. Registrar's Signature Hospital .

NO

		1 - State Registrar	of Maryland / Depa <i>Cer</i>	artment of Health and I tificate of Death		ene2008 31304
Dhysisi	an '	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dav Year
Physici /Medio		Sister Clara Ma		# 01 T		29 2008 4:50 a M
Examir	er	4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of Death Baltimore	1	Baltimore
Funeral		4100 Maple Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Director		191 40 5434 ¹□M 2X□F	91 Yrs.	Months Days Hours Min.	(Month, Day, 1 11/12/19	16 North Carolina
pus *		Usual Residence of Decedent 10a. Stale 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
Marylan f show	lor	Maryland Baltimore	Baltimo	ore		1 □ Yes 2X□ No
r 28a	Directo	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
23a o	raiD	4100 Maple Avenue		21227		U.S.A.
er des Nems Der m	Funeral	Amed f		Was Decedent of Hispanic Origin? (S I Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
irs aft	by F	1 Never Maπied 2 Married 1 □ Yes 3 □ Widowed 4 □ Divorced Year or		1 ☐ Yes 2 X ☐ No Specify:		Specify: Black
be filed within 72 hours after death with the Maryland tal hygiene. dother than "natural", or items 23a or 28a-f show event, ite Medical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Deced	tent's Usual Occupation kind of work done during most of wor	king	6b. Kind of Business/Industry
Athin he.	mple	Elementary/Secondary (0-12) College	(1-4or 5+)	kind of work done during most of wor DO NOT use retired) ious Convent Jobs	ŀ	Religious
Hygiel ther ti		12th 17. Father's Name (First, Middle, Last)	var		ne (First, Middle, M	
id be id be ked o	To Be	Isam B	rown	Cro	ley Mari	ah Brown
2 should and Men is marke	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zip Code)
and and a malth m 27 in		Sister Mary Becker				Maryland 21227
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mandal Hyglens. Important: if item 27 is marked other than "natural, or liems 23s or 28s-f show any injury or other traumatic event, it a Medical Examinating Incominating an angle.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from		sition (Name of natory or other place)		Oc. Location - City or Town, State
iit. Pages artment of ortant: If if injury or o	1	* 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funeral Service Licensee	New Cathe	${ m cdra1}$ ${ m Cemetery}10/0$)2/2008 <u> </u>	Baltimore, Maryland
permit. Departrimports Imports any inju	6	Dans M Rnam				imore, Maryland 21225
111 2		23a. Part1. Enter the disease of semplications that shock, or heart failure. List only one cause or				st, Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ite mypea	/ 1 /	ction	Onset and Death
/Medical Examiner	Н	resulting in death) Due t	o (or as a consequence ol):			
96 ¢	e.	S uentially list conditions, b. Due to	o (or as a consequence of).			
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
The control as, F.C. box ool oo, The law requires that the death certificate be executed as been signed by the attending physician and page 2 thould be detached for use as the burial-transit	I Ex	resulting in death) Last Due t	o (or as a consequence of):			
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at the d by th etache	Phys	9 Unknown		1.00	22a Did tahu	need the contribute to the cause of death?
ires th	by	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	1 ☐ Yes	acco use contribute to the cause of death? s 2 2 No 3 Probably 4 Unknown
requires to	etec	114/100			24a. Was an	24b. Were autopsy findings available
h lav e has	Completed				autopsy perform	prior to completion of cause of
ian: T	a	25. Was case referred to medical		26. Place of Dea	ath (Check only one	
hysic his ce	To B		Inpatient 2 ER/Outpatier		lome 5 Resider	
Ing Ph Iing Ph After th uneral	on:	1 Matural 5 □ Pending (Mo	e of Injury onth, Day Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred
Attending or death. octor: Afte by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - Al home, farm, str			eet and Number or Rural Route Number,
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2. hould be detached for use as	edicai C	(Check only 2 Medical Examiner: On the		h occurred at the time, date and place vestigation, in my opinion, death occu		use(s) and manner as stated. te and place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c. License number	1	d. Date signed (Month, Day, Year)
^		4//	MO	028236	5	ytimber 24,2008
2		30. Name and ad person who completed ca	use of death (Item 23a) (Type,	Print)	+, 1	4/t mb 24,2008
<i>₹</i>		DOVIAN S ST MAN to	MO // Registrar's Signature	cipe IXX 4	1133	alt MD 21228
Regist	ate rar	00101 2008	Holers & A	racks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 5:15 PM 2008 entember ar 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore owson are tospice 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Unde If Linder 24 Hrs **Funeral** Hours Min. Davs 1 M 2 □ F 3 Yrs. Months 243-50-3750 North Caroling Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene, interportant; or items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 22a or 28a-f show any injury or other traumatic event, the Medical Examination of proces. 1 Nes 2 No Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 USA mallwood Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🐪 6 Specify Specify: Black þ 3 ☐ Widowed 4 Novorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aborer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be sore 10 L 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smallwood 9t. Balto. MD 21223 100 N. ore tta daughter ق 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimor 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 30/08 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Howell Funeral Home MD 21207 itahts 4600 Liberty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mosence disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading L. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes ♣No Vital Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Solo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ō this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 29a. Certifier 🕮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decement's Name (First, Middle, Las 2. Date of Death 3. Time of Death **Physician** Month /Medical September Examiner (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1edical Delair artor 9. Birthplace (State or Foreign Country) MARY and Funeral Year If Under 24 Hrs. 8. Date of Birth Month, Day, 1 M 2 M Months Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rediffied at 2008. 10b. Count 10c. City Town or Location 10d. Inside City Limits Funeral Director 1. Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XNo 3₺ Widowed 4 ☐ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland Be Mother's Name (First Middle, Maiden Surname) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, 100 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of BAH. more NA Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2140 North Fulton Avenue 21217 21. Signature of Funeral Service Licensee Funeral Home Baltimore MD ort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Imm ediate Cause (Final disease or condition esulting in death) Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) rrm Due to (or as a conseque Division of Vital Records, P.O. Box 68760 Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy signed by the a d be detached for 4 ☐ Pregnant at time of death 1 ☐Yes 2 ☐No 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Completed peen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAWN DHILLON, MID. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2008 A SHE Drilvin 17 Hev 1/2001

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orpud		30. Name and address of person who co Laron Locke MD. Assista	ompleted cause of death (It ant Medical Examine	,	enn Stree	t, Baltimo	ore, MD	21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31308 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 13, **Physician** 2008 September John Sager Couch, Jr. 5:00 PM /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Healthcare La Plata Charles 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 5, 1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 78 578-36-1605 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, The Medical Evantine must be near that a page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Charles Waldorf 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20602 3605 Moses Way #319 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1™ Yes 2 □ No If Yes, Give Year or Dates: 1951-51 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 2 Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Snack Bar Owner Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be John Sager Couch Dora Stauffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21328 Williams Drive Lexington Park, MD 20653 Dianne Dixon/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory | 09/19/08 4 ☐ Donation 5 ☐ Other (Specify) |Beltsville, MD 21. Signature of Funeral Service I coing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive hear **Physician** disease or condition resulting in death) /Medical Due to (or as a conse sence of): Examiner Endoca Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the burial-tran and Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day ned by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2**X** No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Wedical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D0061652

Registrar

State

30. Name and address of person v

31. Date filed (Month, Day,

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32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director		5. Social Security Number 564 90 2000 Usual Residence of Decedent		(In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08/16/		l Co	thplace (State of ountry) orida	or Foreign
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ς, σ	ires that signed b	by Pt	Part II. Other significant conditi	ons contributing to death bu	t not resulting	in the un	derlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to	o the cause of	
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ital	Physician: The la r this certificate ha ral director, page 2	Be C	25. Was case referred to medica examiner?					26. Place of Dea		/ - /			
of <	Physic this c		1 Yes 2 □ No 27. Manner of Death	Hospital: 1 Inpatie		Outpatien	t 3 ☐ DOA Oth		lome 5 ☐ Res			ecify)	
OU	iding Fith.: After: funera	tion	1 Natural 5 Pendir 2 Accident investi	(Month, Day		Injury 400	Wor	k? Yes 2 No	Car ac		1		
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	To the Hospital or Attending Physician: within 24 hours after death To the Funoral Director: After this certifica completely filled in by the funeral director, p	Medical		ng Physician: To the best on Examiner: On the basis of and manner stat	examination								s)
	To the within To the Comple	Me	29b. Signature and title of certifie				29c. Licens	se number		29d. Date	signed (Mon	th, Day, Year)	
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	1+1		30. Name and address of person		eath (Item 23a	a) (Type, F	Print)	ENE ST	PAIR	MATI	75 W	וכ סו	Pal
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	×.	J. UL	CMC 31	, DHC J	VINO!	11	· y ext	
	Registr		OCT 0 1	2008 Jane	J. K	Do	with I						

			For State of Maryland		rtment of H			2000	31311
В	Registrar 1. Decedent's Name (First, Middle, Last)					eate of Death			3. Time of Death
/Medical -			John F. Dockins				Day Year	8:29p ^M	
)	Exami	ner	4a. Facility Name (If not institution, give street and number) Heart Homes of Linthicum		4b. City, Town, or Linth	icum		4c. County of Dea	ne Arundel
ı	Funeral Director		5. Social Security Number 216-32-4855 6. Sex 7. Age (<i>In yrs. la</i> 7. 3	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 8 / 18 /	(ear) 9. Bir (1935	thplace (State or Foreign ountry) MD
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Loc	cation				10d. Inside City Limits
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	vith the	Funeral Director	10e. Street and Number 1412 Hull Street		10f. Zip Code	24224		g. Citizen of What C	<i>'</i>
	ms 23	neral	11. Marital Status 12. Was Decedent Ever in U.S	3. 13. V	Vas Decedent of His Yes, specify Cubar	2123 (spanic Origin? (Sp		14. Race - Ame	SA erican Indian,
980	be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	Armed Forces? 1 □ Never Married 2 □ Married 1 ★ Married 2 □ No 11 €	Army 1		n, Mexican, Puèrti Specify:	o Rićan, etc.)	Black, Whi	white
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212	d with	l mog	Elementary/Secondary (0-12) College (1-4or 5+) 0		,		Retired	US A	cmy
Maryland		Be	17. Father's Name (First, Middle, Last) Alexander Dockins				e (First, Middle, Ma garet Re	aiden Surname) ichenbei	ra
ary	s 1 and 2 should be f Health and Ments fee 27 is marked other traumatic ev	T ₀	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	nd Number or Du	ent Paula Alumbau (24 T	
	5 ₹ Z ₹		John J. Reichenberg/Cousin	L					1037
nore			MRurial 2 □Cremation 3 □Removal from State Ce.	metery, crem	sition (Name of natory or other place	<i>)</i>		oc. Location - City or Baltimor	
altimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Euneral Service License Victor P. D		A1 1 A 1 1				<u> </u>
n	6 3 5 6		10100	- 1 1	501 E.	L. Stev Fort Av	rens Fun renue, B	eral Hon altimore	ne, Inc. MD 2123
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicating that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the death)	hċ.	ar the mode or dying	n, such as cardiac	or respiratory arres	t,	Approximate Interval Between Offset and Death
8/60,4	70	Physician/Medical Examiner	Sequentially list conditions, larty leading to funding Cause (Disease or injury that initiated events resulting in death) Last b. Cush (casa consequence of): Due to (or as a consequence of):						
ds, P.O. Box 687	ath certifi ttending p or use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal of the p	déath 3⊟l	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
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II Records,		Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
VItal	sician: The la certificate ha irector, page?	Be	25. Was case referred to medical examiner? Hospital:		Othou	,,	th (Check only one)		A (1)
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	ertification: To	27. Mann Death 1 Death 1 Accident investigation 2 Accident (Month, Day Year)	R/Outpatient 28b. Time of Injury	28c. Injury Work? M 1 \(\supers	4 Nursing Ho	ome 5 ☐ Residend 28d. Describe how	ce 6 Dother (Spe injury occurred	city) As(1sted/luin
N	ital or At rs after d al Direct ed in by t	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)				City or Town, S		
	he Hospi n 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and mainer stated.	ledge, death on and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	and due to the cau rred at the time, date	se(s) and manner as e and place, and du	s stated. e to the cause(s)
	To t To t	M	29b. Signature/and this of certifier.		29c. License	number UO9Y	29d	Date signed (Mont	h, Day, Year)
	15		30. Name and address of person who completed cause of death (Item 2	41 b	Madital	K Ore	4, Gen	Burnie	cud, 21061
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registra's Signatu	prete	•			1	

DHMH 17 Rev 1/2001

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AMEND TTEM#20a-c,22,perFH,G884,10/2/08,WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 20 A M James Eadd ent 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bon Secours Hospital
5. Social Security Number 6. Sex Baltimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan 2, 1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days 60 219-50-3333 Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Mcdical Even, iver pust by colling a 1√ Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1703 Wilkens Avenue 21223 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ind Mental Hygiene. marked other than College (1-4or 5+) telemarketing furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evance. John E. Eaddy Agnes Adkins မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Powell/daughter 3600 W. Franklin Street #11N Baltimore, MD 21219 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 9-30-08 **Ardent Crematory** Hanover, MD 4 □ Donation 5 Mether (Specify) in state Name and Address of Facility Ardent Cremation Svcs. 21. Signature Director 2 Connelley Drive Hanover, MD 21076 23a. Par 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final **Physician** Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician as the b IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 274No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide presertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical соmpletely (Check only one) To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 018327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkens Ave Balto Md 21229 Geb (Year) moges 4660 mariam 31. Date filed (Month, Day, 32. Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year LOWERS Physician otember 28 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Months Days Min Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director HIMOVE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Hack 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. ONOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Flowers ဂ္ Maryla 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Columbia, Flowers Ridgeview Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Balto. -08 4 ☐ Donation 5 ☐ Other (Specify) 10-6 21. Signature of Funeral Service Licensee Greene Funeral Services aughn Hd. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OSAR COMA **Physician** /Medical Due to (or as a consequence of) 72 Hours Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 27. Manner of Death Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ္ Man 820 SEPTEMBEL 29 2008

State Registrar 31. Date filed (Month, Day, Year)

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5601 LOCH TIMORE, M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANISHA BAL

BAL

2008

32. Reistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1300 Gamble Adeline 00 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Boyview Medical 5. Social Security Number 6. Sex 7. Age (In yrs. Cente Himere T I If Under 24 Hr Date of Birth 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 🕶 F Months Days Hours Min. Director minia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "hedical Examinan must be notified at 1 Tyes 2 □ No Director カ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Yes 2 1 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕠 10 Specify: à Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumating page. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson ပ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ND 20174 Malboro Tumple-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Daurial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 1to. MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of) o months disease or condition resulting in death) /Medical Examiner mahs Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed HF 10 ments and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Ye ar Day 5 ☐ Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Renay Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy , page Physician: The certificate perform Vital 2 No 2 □No 1 □Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this oţ Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation 1 □Yes 2 □ No 24 hours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name 6

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

ORIGINAL

ss of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

Physician /Medical Examiner Examiner ned by the attending physician and C detached for use as the burial-transit death certificate be executed

sate has been signed by a page 2 should be detach

funeral director,

after death Director:

within 24 hours a

To the Funeral I

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

"natural", or items 23a or 28a-f sl edical Examiner must be notifled

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Funeral Director

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Be

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Morbid

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Physician/Medical

2

Completed

Be

2

Certification:

Medical

State Registrar If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

P0331 ble Sepsis

1 ☐ Yes autopsy perform

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes Yes
27. Manner of Death

1 Inpatient 28a. Date of Injury investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

determined

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

00047979

Hospital Center

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M Michele

31. Date filed (Month, Day, Year)

Carroll 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Rupenh 31. Date filed (Month, Day, Year) OCT 0 1 2008

rtifier

Va Ki

29b. Signature and title of

32. gistrar's Signature

MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
5401 Old court 120dd

MARCE !

29c. License number

000 67620

29d. Date signed (Month, Day, Year)

Randallitown, Marxland

September 26, 2008

21137

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 5:58 PM M Janie Gilbert September 20, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🖫 F Months Days Hours unk 217-30-0191 Director 86 June 30, Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a, State 10b. County 10c. City. Town or Location 28a-f show Examiner must be notified at 1 ☐Yes 2√No Director MD Clinton Prince George's 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 9106 Pineview Lane 20735 USA Funeral items 23a Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No U 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unk 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify Specify: black à 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve once. ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Southern Maryland Hospital 7503 Surraatts Road Clinton, MD20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation & Other (Specify) in s/tate 21. Signature of Funeral Service Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street *i*rector Baltimore, MD 21201 23a. Part 1. Enter the diseas or medications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 1 ☐ Yes 2 No 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28d. Describe how injury occurred 27. Manner of Death 28h. Time of

or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Affer iours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral C

completely filled Hospital

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier

(Check only one)

31. Date filed (Month

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

2008

U

29c. License number 29d. Date signed (Month, Day, Year,

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Veal **Physician** JAMES A. HOPPS 5:30 A SEPTEMBER 23, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S BRADFORD OAKS NURSING HOME CLINTON If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Hours Director 578-26-8546 FEB 2, 1913 Usuel Residence of Decedent with the Maryland 10a. State 10b. County wode 10c. City, Town or Location 10d, Inside City Limits ir than "natural", or Items 23e or 28a-f ehov The Medicul Evantrar must be notified at 1X Yes 2 □ No FORT WASHINGTON MD PRINCE GEORGE'S Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8711 BRIGHTWOOD DRIVE 20744 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4TH BRICK MASON PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever EDWARD HOPPS FRANCIS HOLLY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AGNES HOPPS / DAUGHTER 8711 BRIGHTWOOD DRIVE FT. WASHINGTON, MD 20744 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 5 3 □R moval from State permit. Page Department of Important: If any injury or once. ^ 4 □ Donation _ 5 □ Other (Specify) METROPOLITAN CREMATORY 09-25-2008 ALEXANDRIA, 21. Signature of Fun wall Service Lig 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD nsee SUITLAND, MD 20746 DONALD R. GRAY 4308 SUITLAND ROAD ter the disease, 23a. Part 1 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GASTRIC CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be exec Due to (or as a consequence of): Box 68760. attending physician ian/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery death 3 Ectopic pregnancy jo in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) _ Physici 1 ☐ Yes 2 ☐ No P.O. detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 2X No 3 Probably 4 Unknown 1 🗌 Yes peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2□ No 1 🗌 Yes 2**X** No Hospitel or Attending Physician: 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death.

Director: Aft investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier t 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number emu D35206 SEPTEMBER 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20744 WILLIAM TANNER 11701 LIVINGSTON ROAD #101 FT. WASHINGTON, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 1 2008 Registra

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 5 C P T **Physician** 10.45AM 27 2008 IRWIN RENA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner toward Nursing + Kehab olumbia rien ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🕶 F Derember 1, 1914 9.3 Yrs. Maryland 218-05-3548 Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic avent, the Medical Examiner must be notified at 1 Nes 2 No olumbia Director the 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ŏ 2104 3125 or itame 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status ☐Yes 2 1006 Yes, Give 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify: ģ 3 Nidowed 4 □ Divorced Year or Dates: "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within : nent of Health and Mental Hygiene. int: if Itam 27 ie marked other than " College (1-4or 5+) Elementary/Secondary (0-12) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Kena Dimms imms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balk. MD 21244 3502 Washington Ave ohn9onletta triend 20b. Place of Disposition (Name of cometery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. South e of Funeral Service Licensee 22. Name and Address 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA monet /Medical Due to (or as a consequence of): Examiner ATHEOLOSCLEROSIS Years CORONAN Caquantially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit ATION TRIAZ F188122 Due to (or as a consequence of) the attending physicien hed for use as the buria P.O. Box 68760 thruva Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 thknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospitaf: 2 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. After t Certification: Injury at Work? the Hospital or Attending Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Puneral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Suple MD 2008 SEBT 27 2005315 1 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) senhajo Ro sup Le Shakunmale olumbu Registrar's Signature 31. Date filed (Month, Day, Year) 21045 State OCT 0 1 2008 Registrar

08-07314

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Donald lardella 2008 31320 Certificate of Death 1- For State Req. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month 2014 hrs September 25, 2008 Medical Examiner Donald R. Iardella, Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford. Joppa 2306 Reckord Road g. Birthplace (State or If Under 1 Year If Under 24Hrs. 8: Date of Birth (MM/DD/YYYY) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Months Days Hours Country) MD 03-06-1943 Director 1X M 2 65 217-40-9975 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ę 10a. State 10b. County Yes 2 X No MD Harford Joppa 28a-f shov with the Maryland rector 10g. Citizen of What Country? 10f, Zip Code s 23a or 28a-f notified at o 10e. Street and Number 2306 Reckord Rd 21085 USA 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Funera White, etc. or items must be Armed Forces? Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Never Married 2 X Married 1 X Yes White Yes 2 X No specify: Specify: If Yes, Give Year Divorced Widowed 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) other than " IRS Tax Consultant 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Emma Kraeter Be Donald R. Iardello Sr MD 2121 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Iradella (Wife) 2306 Reckord Rd Joppa, MD 21085 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, Baltimore, I permit. Pages I and Department of Heal 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 10-01-2008 Baltimore, MD Joseph Cemetery Donation 5 Other Specify: or 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home MacPhail Rd Bel Air, MD 2 BelAir 610 W. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death Morting a. Hanging Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED physician the burial -UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth attending | past 12 months' Pregnant at time of death 5 Other (Specify) ned by the atte detached for t 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✔ No 3 Probably 4 þ Completed 24b. Were autopsy findings available Division of Vital Records, 24a. Was an prior to completion of cause of autopsy . death? performed? Yes 2 V No Yes 2 No certificate h 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medica Be Other₄ Residence 6 V Other: Scene Hospital: 1 Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 27. Manner of Death After Subject hanged self Certification: FOUND: Yes 2 ✔ No Natural 5 Pending death. 1930 hrs Sep 25, 2008 Director: 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 2306 Reckord Road, Joppa, MD 3 🗸 Suicide Could not be determined (Specify) Single Family To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 26, 2008 O.C.M.E. D 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29, Year 008 10:25 PM **Physician** Elizabeth Lutz Joesting /Medical 4a. Facility Name (If not institution, give street and number)
Upper Chesapeake Hospital 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Bel Air If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/22/1918 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) MD country) **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F 163-18-3345 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov "natural", or items 23a or 28a-f sho MD 1 ☐ Yes 2 ☐ No Harford Jarrettsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21084 3041 Rocks Road Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates þ Specify: White 3 Widowed 4 □ Divorced Completed traumatic event, I've Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Board of Elections College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Harford Co. Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be i Charles Otto Lutz Mary Bertha Cullum ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 single between of Health an Important: If item 27 is any Injury or other traus David Joesting/Son 3877 Paul Mill Road Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Oct 2 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine a consequence of) physician and the burial-transit Due to (or as a consequence of): Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy 5 Other (specify) □Yes 2 No 9 Ulnknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 certificate 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After the 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year,

7

State Registrar

mohammana 31. Date filed (Month, Day, Year) 1 0

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** 1- For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Medical Examiner 0301 hrs VAN JOHNSON, JR. September 24, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hosptial Center Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9: Birthplace (State or **Funeral** Months Days Hours Min. Director Country) 579-19-3095 1 X M 28 2-16-1979 Usual Residence of Deceder iny 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show DC with the Maryland WASHINGTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 WILMINGTON PLACE, SE #4 20032 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene, and the title that Transmite is marked other than "matural", or item and other transmite event, the Medical Examiner must be of other transmatic event, the Medical Examiner must he White, etc. X Never Married Yes 2 X No If Yes, Give Year Yes 2 X No specify: Widowed 4 Divorced Specify: BLACK 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 10TH **JANITOR** PRIVATE 18.Mother's Name (First, Middle, Maiden Surname). 17. Father's Name (First, Middle, Last) Be VAN JOHNSON MICHELLE STALEY ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY WALKER/GRANDMOTHER 106 WILMINGTON PLACE, SE #4 WASHINGTON, DC 20032 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial Cremation 3 permit. Page:
Department o
Important:
injury or oth HARMONY MEMORIAL PARK 10-03-2008 LANDOVER, MD Donation 5 Other Specify 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD Service Licensee DONALD R. GRAY 20746 4308 SUITLAND ROAD SUITLAND, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** fallure. List only one cause on each line Between Onset and /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical physician the burial -UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months Pregnant at time of death 5 Other (Specify, signed by the atter No 9 Unknown Yes 2 Unknown q Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, ficate has been so page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' certificate ✓ Yes 2 ~ Yes No the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: this Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other ဂ္ 1 🗸 Yes No After 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Sep 24, 2008 Subject shot Natural 0205 hrs Pending Yes 2 V No within 24 hours after death. To the Funeral Director: filled in by the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 4100 Branch Avenue, Temple Hills, MD determined (Specify) Major Road / Highway 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

32. Régistrar's Signature

Assistant Medical Examiner

0

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

September 24, 2008

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

			1 _ State		artment of Health and rtificate of Death	Mental Hygier	2008	31323
	Physicia /Medic		Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
			ALMA ARLENE JONES-JORDA	N		Month SEPTEMBER	25, 2008	1930 ™
-	Examin		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or Location of Deat		4c. County of Death	
mark of the			WASHINGTON ADVENTIST HOSE	'ITAL	TAKOMA PARK		MONTGOME	
1.	Funeral		1□M 2▼ =	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Yea		lace (State or Foreign try)
	Director		577-56-8161 Sual Residence of Decedent	97		APRIL 30,	1911 NC	
	aryland show		10a. State 10b. County	10c. City, Town or Lo	cation		10	0d. Inside City Limits
	Mary a-f sh ified	ctor	MD PRINCE GEORGE'S	MT. RAIN	TER			1 X Yes 2□No
	th the or 28, e not	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
	th will		4507 RUSSELL AVENUE		20712		SA	
	tems term	nue	11. Marital Status 12. Was Decede Armed Force		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, e	
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 23a-f show ent, it a Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 { If Yes, Give Year or Date		1 ∐Yes 2 X No Specify:		Specify: BI	ACK
9	tural		15. Decedent's Education	16a. Dece	dent's Usual Occupation		Kind of Business/Ind	
215	nin 72 in "ne in file	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	`life.	kind of work done during most of wo DO NOT use retired)	rking		
2	d with	Son	12TH	CLER			SPS	
p	2 should be filed within and Mental Hygiene. Is marked other than ' aumatic event, It e M	Be (17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	len Surname)	
<u> </u>	should be fand Mental semarked o	٦	ADOLPHUS JONES		PEARL I			
Maryland 21215-0036			19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or R			
e e	1 and 1 Health em 27		PEARL ARLENE HUSKINS/DAUG 20a. Method of Disposition			WASHINGTO Date 20c.	Location - City or To	744 wn, State
jo L	ages ent of t: If it y or o		1 Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	ie i	psition (Name of matory or other place) EMORIAL CEM. 10-0	3-2008 SI	UITLAND, M	m
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funghal Service Licensee		2. Name and Address of Facility MA			
ä	Dep any onc		DONALD		4308 SUITLAND ROA			0746
			23a. Part Enter the disease or complications that caus shoot, or heart failure. List only one cause on each	sed the death. Do not en	ter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
~	Physician		Immediate Cause (Final disease or condition	5	LPSIS			Onset and Death
	/Medical		resulting in death)	as a consequence of):	1			
	Examiner	_	Sequentially list conditions, b.					
	led sit	nine	if any, leading to immediate Due to (or cause. Enter Underlying Cause (Disease or injury	as a consequence of):				
PX	execut and al-trar	Examiner	that initiated events c	as a consequence of):				
8760,	The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E	U d					
1 89	tificat ig phy as the	ledic	U					
Box	leath certific attending p	N/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the program of the pr		☐ Ectopic pregnancy		23d. Date of delive	•
<u>.</u>	ed for	Physician/Me	1 ☐Yes 2 🗓 No 4 ☐ Pregnar	t at time of death 5	Other (specify)		Month	Day Year
<u>о</u> О	res that the de signed by the a be detached f	Phy	9 Unknown	but not reculting in the u	nderlying cause given in Part I	23e Did tobaco	o use contribute to the	ne cause of death?
Records,	ires the signer of the distance of the distanc							
Š	w require s been si should b	Completed by						nov findings available
Rec	e has	mp				24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
ā	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		25. Was case referred to medical		26. Place of Do	1 □Yes 2 ☑ ath (Check only one)	No 1 □Yes	2 🗹 No
5		o Be	examiner?	atient 2 🔲 ER/Outpatie	Other	Home 5 Residence	6 ∏Other (Specif	(v)
٥		Certification: To	27. Manne of Death 28a. Date of I	28c. Injury at Work? 28d. Describe how injury occurred				
Ö	endin ath. ir: Aff	atio	2 Accident investigation	Day, Year) Injury	M 1 ☐Yes 2 ☐No			
Division of Vital	al or Attendii s after death. Il Director: A	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, str etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t a <i>nd Number</i> or Rura tate)	al Route Number,
Ω	urs af aral D		177 O 177 O		the second of th		-(-)	-ttd
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Physician: To the beasione) 1 Medical Examiner: On the basione	s of examination and/or in				
	fo the vithin fo the	Me	29b. Signature and title of certifier	1 5	29c. License number	29d.	Date signed (Month,	Day, Year)
	7 - 3		> // Let M	5018	D4547	-1	9/3	25/18
	(0)		30. Name and address of person who completed cause of	of death (Item 23a) (Type,	Print) 7600 Carroll A	venue Tak	oma Park,	MD 20912
	٣		Ytheyis Algu	5512 (m	· D Woh	-Pton	HOV. 1	Wester
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regi	istrar's Signature		•		_
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 15:30 **Physician** amisor /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Nursing Center Ween HIMOre 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 M 2□ F Months Days Hours Min Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County show 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be nothed at 1 XYes 2 ☐ No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other trainments. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. ۵ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tanke litary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lamison ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10/1/08 1 ☐ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License laur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEPSI. Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed ATHENOSCLEILOSI sician and burial-trans ORONAMY Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1∐Yes 2∐No cate has been signed by the page 2 should be detached 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 □ Yes 2 ☑ No To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 □ NG 1 ☐ Yes ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Shakunmale

MIS

ple

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

9650

29c. License number

00053150

sanhaford suite 110

29d. Date signed (Month, Day, Year)

2008

21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Q Month **Physician** Day Year 26, 2008 enkmber 2:00 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery
9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) Trove 4d ventist 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🖫 F Months Hours Min. Director May Korea Usual Residence of Decedent death with the Maryland 10a. State 10b. County f show 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f sho Director 1 Nes 2 No redericks build 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA d be filed within 72 hours after deat ental Hygiene. ked other than "natural", or items ? ic event, the Medical Examination in the Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 □Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married □Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: δ Specify Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) touse wife 12 lomestic h and Mental Hygie ' is marked other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Sae ona ပ 19a. Informant's Name/Relationship ype. Print) 19b. Mailing Address (Street and Number or Rural Route Num er, City or Town, State, Zip Code) Rd Chang 40 Ellington Fredericksburg, VA 22406 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 30/08 21. Signature of Paneral Service Lice ee 22. Name and Address of Facility 20794 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardioc Quelmore disease or condition resulting in death) 10 mounts /Medical Due to (or as a consequence of): Examiner Intre Cranut Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit g g Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year signed by the a d be detached f 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 1 □ Yes 2 No 2 🗆 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To oto After this 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deatle Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00065505 September 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville. MD Center Dr. 9901 Medical QIUFANG M.D.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 27, 2008 **Physician** 6:00 A M LiPira Domenica /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3804 Collier Road Baltimore Randallstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Days 1 M 2 Ty Months Italy 212-50-6483 85 July 10 1923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hyglene.
smit if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, ih. Madical Examiner must be recitived any or other traumatic event, ih. Madical Examiner must be recitived as 1 ☐ Yes 2X No Director MD Baltimore Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3804 Collier Road 21133 Italy Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 □Yes 2 √ No Specify Specify. white Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clothing seamstress 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Filippo Fertitta Giuseppa Curo ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. 3804 Collier Rd., Randallstown, MD 21133 Domenico LiPira (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 10-2-08 4 Donation 5 Other (Specifyentombment Woodlawn Cemetery 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paige Spaight of P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tong uc Immediate Cause (Final disease or condition resulting in death) **Physician** N /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Funcis after death.

Function and After this certificate has been signed by the attending physician and the presence of the function process. The process of the process of signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 \sum Nursing Home Hospital: 1 Yes, 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 A Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

Nel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ermm

32. Registrar's Signature

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			For State	State of Mary		epartmen <i>Certificat</i>				giene Reg. No. 20	08	3 3	27
			Registrar 1. Decedent's Name (First, Middle, Las.	r)			or boat		2. Date of De	ath		3. Time of D	
	Physicia /Medic		Marie Clair Llove	ì					Month Septe	mber 29	Year 2008	7:15	AM ^M
	Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or Location	on of Death		4c. County	of Death		
~ _			Gilchrist Center			hdav) If Under		wson der 24 Hrs.	9 Date of Bir		imore	ace (State or	Foreign
٠	Funeral Director			M 2 F 7. Age (/	In yrs. last birti 80	rs. Months	Days Hour		8. Date of Bir (Month, Da	ay, Year)	Count		Foreign
			212-24-7883 Usual Residence of Decedent		80				02/28	3/1928	MD		
	rylan how	_	10a. State 10b. County	10	0c. City, Town	or Location					10	d. Inside City	/
	e Ma 8a-f s	Director		re City	Balti							1 □Yes Ž	No No
	with the		10e. Street and Number			10f. Zip				10g. Citizen of	What Count	ry?	
	eath '	Funeral	6130 Allwood Ct. 11. Marital Status	#321 12. Was Decedent Eve	er in U.S.		.210 lent of Hispanic	Origin? (Spe	ecify Yes or No	USA 14. Ra	ce - America	n Indian.	
39	be flied within 72 hours after death with the Maryland Hygiene. It Hygiene. d other than "natural", or items 23a or 28a-f show event, I're Madical Evanit er mist be rediffed at	þ	1 □ Never Married 2 □ Married 3 ➡ Widowed 4 □ Divorced	Armed Forces? 1 ⊡Yes 2 No If Yes, Give Year or Dates:		13. Was Deced If Yes, spec 1 □Yes 2			Rican, etc.)	Bla Specif	ck, White, et	c.	
Ģ	"2 hou	ted	15. Decedent's Edu (Specify only highest grad		16a.	l Decedent's Usua (Give kind of wol	al Occupation	most of worki	na	16b. Kind of B			
21	tthin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT us	e retired)	nosi di woiki	rig	Print	ing		
2	led wi tygier her th		10		В	ook Keer		other's Nome	(Eiret Middle	, Maiden Surnar	na)		
_	4 = 0 =	Be c	17. Father's Name (First, Middle, Last) Wilmer G. Smith				ĺ		K. Eber		110)		
ir Z	shoulk nd Me mark imatik	은	19a. Informant's Name/Relationship (7	ype. Print)	19b.	Mailing Address					, State, Zip	Code)	
Ĕ	und 2 alth a 27 is er trau		Linda Lloyd/Daught	er	3	601 Han	cock St	. Amar	illo,	TX 79109)		
Ö.	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Dames val from State	20b. Place of cemeter	Disposition (Nan y, crematory or o	ne of ther place)		Date	20c. Location	- City or Tov	vn, State	
Ĕ	Рад ment ant: I		4 □ Donation 5 □ Other (Specify	Removal from State	1	peake C		v v	0ct 1 2008	Beltsv	ille,	Marylan	nd
Baltimore, Maryland 21215-0036	permit Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Licens	M0149	3	Crema	d Address of Fa	Funera		natives Baltimor	o Mar	ng and	
	hysician /Medical		23a. Part 1. Ever the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	REAT	ot enter the mod	e of dying, such					Approximate interval Betwoonset and De Market	eath
	Examiner		1	•	onsequence o	1).							
	± q	ner	if any leading to immediate	b. Due to (or as a c	onsequence o	f):							
K	and and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		D.							
£8760, ≪	fricate be executed if physician and sthe burial-transit	al E	rooding in doday East	Due to (or as a c	onsequence o	11):							
687	ficate p physis the	edical		d									
Box	leath certific attending p	M/u	23b. was decedent pregnant	23c. If yes, outcome of p		3 ☐ Ectopic p	recognos				ate of delive		
P.O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐Yes 2 Mo 9 ☐ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown		5 ☐ Other (sp				М	onth I	Day Ye	ear
Vital Records, F	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions of	entributing to death but n	not resulting in	the underlying c	ause given in Pa	art I.		tobacco use con Yes 2 □ No		e cause of de ably 4 ☐ Ur	
 တ္တ	s beer	Completed							24a. Was		Were autop	sy findings a	vailable
Re-	The law ite has	duo							auto perfe 1 □ Yes	ormed?	prior to con death? 1 ☐ Yes	npletion of car	use of
		Be C	25. Was case referred to medical examiner?			-	26. P	lace of Deat	n (Check only		10163		
≒	Je isis		1 ☐ Yes 2 No			tpatient 3 🗆 DC				idence 6 🔼 Ot		HOSP	162
Ĕ	ding Physl h. After this c funeral dire	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Y	<i>'ear)</i> 28b. T		8c. Injury at Work?		28d. Describe	how injury occur	red		
Division of	Pr: at	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury	- At home far	M street factors	1 ☐ Yes 2	1	28f Location	Street and Num	her or Rural	Route Numb	er l
2	after after Direct	Certification: To	4 ☐ Homicide determined	28e. Place of Injury building, etc. ((Specify)	iii, street, lactory	, onice		City or To	wn, State)	ber or marar	rioute rumb	01,
	Io the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C		/sician: To the best of r iner: On the basis of ex and manner stated	xamination and								
	Vithir Comp	Me	29b. Signature and title of certifier	>		290	c. License numb	per		29d. Date sign	ed (Month, L	Day, Year)	
			100	al a		D	6439.	5		SEPTE	MBER	29.2	008
	10		30. Name and address of person who					e-11:	0.00	24:-	-44		
	(BANIEUL DOBERA 31. Date filed (Month Day, Year)	AN, MD (Signature	N CHARL	£5 51, 8	suite	209	BALTIMO	RE, M	0 212	04
	Sta Registr		OCT (71 2)	008	July	franks)	r						

09/29/2008

Patient Known as Suste Lemon Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			ype or Print					-		_		
		1 _ State	State of Mar		epartmei <i>Certifica</i>			-	giene Reg. No.	0000	3	1328
		Registrar 1. Decedent's Name (First, Middle, Last)		•				2. Date of De	eath		3. Time	of Death
Physic /Med		SUSIE M	THE L	EM	ON			Septem	Day	Year 2008	0	1;03€
Exam		4a. Facility Name (If not institution, give s	treet and number)		4b. City	, Town, o	r Location of Death	7		County of Death	1	
2		Sinai Hospital	LOP Ball	more	Ba	r 1 Year	OSE City	8. Date of Bir	rth.	N/A	polaco (Stat	e or Foreign
Funera Directo		5. Social Security Number 6. Sex	M 2 K F 7. Age (In yrs. last birth	Months		Hours Min.	Month, Day	av. Year)	Con	intry) AROLI	
	'	Usual Residence of Decedent						SUNC	10)1	ع,ر رسر		
arylan show	Ļ	10a. State 10b. County		0c. City, Town							10d. Inside	City Limits es 2 ☐ No
he Ma 28a-f	Director	MARYLAND NIA	وا	BALTI		p Code	174		10a Citi	izen of What Co		.5 2 140
with t		2503 N. HILTO	AL STRE	ET			16		•	S.A.	arid y :	
filed within 72 hours after death with the Maryland Hygiene. Hygiene was a state of the state of	Funeral		2. Was Decedent Eve				lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	0-	14. Race - Ame		
after o		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give		lf Yes, spe		an, Mexican, Puerto Specify:	Hican, etc.)		Black, White	, etc.	,
72 hours "natural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								HUK	1
n 72 h	lete	15. Decedent's Educi (Specify only highest grade	completed)	1 (Decedent's Usi 'Give kind of w life. DO NOT i	ork done	during most of worl	king	160. KI	ind of Business/I	ngustry	
be filed within 72 hat Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	H	DUSE	K	EEPING	?	PR	IVATE	MC	MES
e filed al Hyg othe	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle	, Maiden	Surname)		
2 should be and Mental Is marked or aumatic ev	일	WILLIAM	C. L.	EMC			PHYLL			GARK		
1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the Menter traumatic event ev		19a. Informant's Name/Relationship (Typ		1 '		•	and Number or Ru				· .	,
s 1 and of Health item 27	L S	CARRIE BELL MCF. 20a. Method of Disposition		20b. Place of I cemetery				Date Date		ocation - City or		<u></u>
J 0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery MT-ZI	, crematory`or	other plac	ERY 10-	4-08	IAN	SDOWN	IE, MA	RYLAND
inje grafit	ė	21. Signature of Funeral Service License		11110 ZI				, , = 1 2 =			~~~	
an per g	ā	1 Dietuch.	N. Will	iamo	2140 P	U. F	ss of Facility BROWN JLTON A	IE., BAL	TIM	ORE, M	0 813	217
		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	e death. Do no							Approxin Interval f Onset ar	nate Between
Physician	_	Immediate Cause (Final disease or condition resulting in death)	Adult	Respir	satory	Dis	Freez Su	ndrom	e		lda	NY
/Medica Examine	-	resulting in death)	Due to (or as a c	onsequence of): /		,				21.	
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of	- SY Nol	rom	٥				2010	42
executed and and and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Metach	alic L	JYPK	Dise	ase				1100	45
_ a _a _ =	EX	resulting in death) Last	Due to (or as a c	onsequence of	j):							,
	edica	d.										
certifii ding I	/Me	IF FEMALE:	3c. If yes, outcome of	pregnancy						23d. Date of del	ivory	
leath atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 I 4 ☐ Pregnant at tir	Fetal death	3 Ectopic 5 Other (s		су			Month	Day	Year
at the de by the stached	Physician/M	9 Unknown	9 Unknown									
res that signed be det	by P	Part II. Other significant conditions conf	tributing to death but r	not resulting in	the underlying	cause giv	en in Part I.			use contribute to		
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e law has b	Completed							24a. Was		24b. Were au prior to death?	topsy findin completion o	gs available of cause of
sician: The certificate h								1 □ Yes	2 N o		212No	
sicial s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	2 □ EB/Out	patient 3 🗆 🗈	OA Oth	26. Place of Dea	,		6 □Other (Spe	oifu)	
g Phys er this eral dii		27. Manner of Death	28a. Date of Injury (Month, Day,	28b. Ti		28c. Inju Wor		28d. Describe			UIIY)	
ending leath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(INGINIT, Day, 1	bai)	M		Yes 2□No					
or Atter de lirecte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farr (Specify)	m, street, facto	ry, office			(Street ar wn, State	nd Number or Ru e)	ıral Route N	umber,
pital ours a eral C		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge	death occurre	d at the ti	ime date and place	and due to the	e cause(s	and manner a	s stated.	
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only 2 Medical Examinone)	er: On the basis of e	xamination and	I/or investigation	on, in my	opinion, death occu	rred at the time	, date an	d place, and due	to the caus	
To th withir To th	Me	29b. Signature and title of certifler	00.		25	9c. Licens	se number		29d. Da	te signed (Mont	h, Day, Yea)
		▶ K. Kusuma	MBBS			KE	3-000		Sept	tember,	25,	2008
N		30. Name and address of person who cor	npleted cause of dea	th (Item 23a) (Type, Print)	0 11	se number S-000 ospital	. 0 0	110	16-		
, ,	tate	31. Date filed (Month, Day, Year)	32. Aegistrar's	Signature	Dino	uH	urital	OF BO	altin	nove		
Regis		OCT 0 1 200	38 / 100/1/5.	o All.	Marke	AT .						

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 1 - Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Jane Little September 18, 2008 3:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Street
|| Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Months | Days | Hours | Min. | May 24, 192 3569 Mill Green Road Harford 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 211-18-4147 83 1925 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 Is marked othsr than "natural", or Itams 23a or 28a-f ahow traumatic avent, the Medical Examinar must be notified at 1 Yes 2 No Director MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3569 Mill Green Road 21154 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify:white 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 cook/waitress food industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Francis McCauley Agnes Clare McCarty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Sams/daughter Item 27 other tra 3569 Mill Green Road Street, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H Important: If Ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signatur of Funeral Service Roll and **Wirector** mi Approximate
Interval Between
Onset and Death
Six Mon 23a. Part1. Enter the disease, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Squamous Metastatic **Physician** Cavanama /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ol): Examine attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) certificete has been signed by the a rector, page 2 should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 Probably 1 ☐ Yes 2 ☐ No 4 □Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 1 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time ol 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print) 4 Vickory Wenre your 2. Registrar's Signature 31. Date filed (Month State Registrar

Physician /Medical

Physician /Medical

Examiner

Director

by Funeral

Be Completed

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Medical Certification: To Be Completed by Physician/Medical Examiner

30. Name and address of person who completed ca

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31. Date filed (Month, Day, Year)

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral

Director

Please Type or Print in BI State of Maryland				-	_	
1 - State Registrar		tificate of		, ,	3.No. 2 1 1 1	3 31330
1. Decedent's Name (First, Middle, Last) Bernard Alvin Miller				2. Date of Death Month Sentemb	er 26, Year	3. Time of Death 08 7:33pm ^M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	Бересшь	4c. County of Dea	
5310 Fleming Road 5. Social Security Number 6. Sex 7. Age (In vrs. fa:	- 6 l- :- 10 - 11)	Mt.	Airy If Under 24 Hrs.	Lo Bata d Birth	Carro1	
5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last 1 M 2 ☐ F 81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 16,	Year) 1926 9. Bir	rthplace (State or Foreign ountry) PA
Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation				10d. Inside City Limits
MD Carroll		Mt.	Airy			1 □Yes 2 □XNo
10e. Street and Number		10f. Zip Code	,	10	g. Citizen of What Co	ountry?
5310 Fleming Road		217			USA	
11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Widowed 4 ☐ Morried 3 ☐ Widowed 4 ☐ Morried 3 ☐ Widowed 4 ☐ Morried 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give T Year or Dates:		Vas Decedent of H FYes, specify Cub ☐Yes 2☐ \ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E	OO NOT use retired	durina most of work	ing 1	6b. Kind of Business	
6	Plui	mber	40 Markarda Nasa	. (First triad) - tr	Plumbi	ng
17. Father's Name (First, Middle, Last) Ralph Miller			Grad	_{e (First, Middle, Ma} ce Koont	,	
19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Rui		City or Town, State,	Zip Code)
Mrs. Rebecca Livesay (Daughter)	5310	Fleming	Road Mt.	Airy, MI	21771 Dc. Location - City or	
N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	netery, crem	atory or otner pla	ce)			
4 Donation 5 Other (Specify) Lak 21. Signature of Funeral Service Licensee j					ykesville	e, MD
		AIGHT FUI	ss of Facility VERAL HOMI 195 Sykes	E & CHAPE	L, P.A.	
23a. Part 1. Enter the disease, or complications t ₁ al caused the death. shock, or heart failure. List only one cause — each line.						Approximate
Immediate Cause (Final disease or condition	WA	m fa	Jum.			Interval Between Onset and Death
resulting in death) a. Due to (or as , conseque	nce of):	1	V			
Sequentially list conditions,	ey	Cmu	ev			
cause. Enter Underlying Cause (Disease or injury	Dr	netic	. well	ha II		
that initiated events resulting in death) Last c. Due to (or as a conseque	nce of):	, , ,		101		
d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of decent pregnant 2 ☐ Fetal d 9 ☐ Unknown	eath 3	Ectopic pregnand Other (specify)	у		23d. Date of de	elivery Day Year
9 Unknown Part II. Other significant conditions contributing to death but not resulting to death but	ing in the un	iderlying cause giv	en in Part I.		acco use contribute t	./
Capacita have been a first						robably 4 Mnknown
- congistra mor tall	m	,		24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
25. Was case referred to medical examiner? 1 Yesy 2 No Hospital: 1 Innatient 2 Fi	2/2	t 3 🗆 DOA Oth	er·	h (Check only one,		
27. Man r of Death 28a. Date of Injury 2	8b. Time of	28c. Inju	v at	ome 5 Resider 28d. Describe how	ce 6 Other (Speringly occurred)	ecify)
1 ▼ Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	Injury	M 1□	k? Yes 2 □ No			
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
29a. Certifier (Check only one) Certifying Physician: To the best of my knowl Medical Examiner: On the basis of examination and manner stated.	edge, death on and/or inv	occurred at the ti restigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	as stated. e to the cause(s)
29b. Signature and title of cellifier		29c. Licens	3359	9	d. Date signed (Mon	th, Day Year)

Registrar DHMH 17 Rev 1/2001

State

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ments!

Destminster, MD 21157

use of death (Item 23a) (Type, Print)

ve Suit Registrar's Signature

	-	State of Mary - State Registrar	•	ent of Health and atte of Death	Mental Hygier Reg. I	0000 0100
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Charles Edward Mixter			Septembe	
Examin Funeral Director	C1	1 N 2 1 E		ty, Town, or Location of Deat Timonium der 1 Year If Under 24 Hrs is Days Hours Min.	n 8. Date of Birth	
show	_	Usual Residence of Decedent	c. City, Town or Location			10d. Inside City Limits
a or 28a-f	Director	MD Baltimore City 10e. Street and Number		Zip Code		Citizen of What Country?
is I amous should be litted within 12 mous after bearth with the manyanto the facility and the that I Hygiene. If Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be multified at	by Funeral	3838 Roland Avenue 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13. Was De	21211 pedent of Hispanic Origin? (specify Cuban, Mexican, Puer 2 Mo Specify:		SA 14. Race - American Indian, Black, White, etc. Specify: White
giene. grene. er than "natura Ibe Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NOT	work done during most of wo use retired)	rking	Kind of Business/Industry
ld be inco	To Be C	17. Father's Name (First, Middle, Last) William Henry Mixter			me (First, Middle, Maid Naomi Shoffe	•
Ith and M	F	19a. Informant's Name/Relationship (Type. Print) Ted Mixter/Nephew				ty or Town, State, Zip Code)
perfull. Fages I and a Department of Health a Important: If item 27 Is any injury or other tra once.		·	Ob. Place of Disposition (Posemetery, crematory of Chesapeake	vame of trother place)	Date 20c Sep 30	Location - City or Town, State
Departm Departm Importa any Inju once.		21. Signafure of Funeral Service Licensee	443 22. Name Crem	and Address of Facility ation and Fune:	ral Alternat	
hysician /Medical xaminer	cal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ENCEPHAL Due to (or as a cool of the cause). But the cause if any, leading to immediate cause. Enter Underwind Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a cool of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cool of the cause (Disease or injury that initiated events resulting in death) Last	nsequence of):			Interval Between Onset and Death
in the frostnan or Attending Frystrant, the taw requires that the death centure are the fritting at hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 Ectop	c pregnancy (specify)		23d. Date of delivery Month Day Year
unes that the us signed by the a Id be detached f		Part II. Other significant conditions contributing to death but no	ot resulting in the underlyin	g cause given in Part I.		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 🕱 Unkno
cate has been s page 2 should	Completed by				24a. Was an autopsy performed 1 □Yes 2 X	
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	2 ER/Outpatient 3 Description 28b. Time of Injury	Other:	ath (Check only one) Home 5 Residence 28d. Describe how in	e 6 \(\)Other (Specify) HOSPICE injury occurred
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident investigation	At home, farm, street, fact Specify)	1 ☐ Yes 2 ☐ No cory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
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e F		201 0:		29c. License number	29d.	Date signed (Month, Day, Year)
within 24 To the F	Me	29b. Signature and title of certifier 30. Nam and address of person who completed cause of eath		DS274	-0	09/50/08

OCT 0 1 2008

Physician

/Medical

Examiner

Be Completed by Funeral Director

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Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

OCT 01

2008

For							lental Hy		0	0 -	
State Registrar			Cei	rtificate c	of Death	1		Reg. No.	2	0.08	3 3 1 3 3
Decedent's Name (First, Midd	lle, Last)						2. Date of De Month	Day		Year	3. Time of Death
ROSEMARY Mo	FADDEN						1	27	5	100B	7:16AM
Facility Name (If not institution	nn, give street and nu	ımber)		4b. City, Tow	n, or Location	of Death				y of Death	
PRINCE GEORGE					/ERLY				RIN		EORGE'S
Social Security Number 577-88-0721	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I		If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Bir (Month, Da NOV • 9	lay, Year)			hplace (State or Foreign untry)
ual Residence of Decedent											104 12-12-60
. State 10b. County	y E GEORGE'S		y, Town or Lo								10d. Inside City Limits 1 X Yes 2 ☐ No
MD PRINCI 2. Street and Number	L GEORGE 2	, п1.	V L	10f. Zip Cod	de			10g. Cit	izen of	What Co	untry?
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4814 56TH AVEI	12. Was Dec	cedent Ever in U.	S. 13	Was Decedent If Yes, specify (rigin? (Sr	pecify Yes or No		14. Ra		rican Indian,
. Marital Status 1 ☐ Never Married 2 ☒ Ma	Armed F	orces? 2 N No					Hican, etc.)		Bla	ack, White	
3 ☐ Widowed 4 ☐ Divorce	If Yes, G	ive		1 ☐ Yes 2🂢	No Specify	<i>y</i> :			Speci	B)	LACK
15. Decede	ent's Education		16a. Dece	dent's Usual Oc	ccupation	iet = "	kina	16b. K	and of E	Business/I	
(Specify only high	est grade completed,		(Give	e kind of work do DO NOT use re	lone during mo	oi ot work	ang				
Elementary/Secondary (0-12)	4 YRS	(1-4or 5+)	PRIN					P	PRIV	ATE	
Father's Name (First, Middle					18. Moth	her's Nam	ne (First, Middle	e, Maider	Surna	ime)	
ELLIS MIMMS.					GEN	INETT	E MARSE	HALL			
a. Informant's Name/Relation			19b. Maili	ing Address (St					or Towr	ı, State. 7	Zip Code)
a. Informant's Name/Helation RONNIE McFADD		ISBAND		56TH A			ATTSVIL			2078	
a. Method of Disposition		20b. F	Place of Dispo	osition (Name o	of i		Date				Town, State
1 X Burial 2 ☐ Cremation		n State St	emetery cre John	matory or other S CME	r place)						
4 Donation 5 ☐ Other ((Specify)		urch C	emeterv	7		4-2008			BURG	
. Signature of Fundral Service	< /										OME OF MD
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		(a) W	Ver.	Ú.		as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** entember /Medical City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street an Examiner HOSO andalistoun 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. Le La Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21117 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ res 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12 years College (1-4or 5+) eacher altimae years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be ပ္ 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of cemetery, crematory or other Oa. Method of Disposition 20c. Location - Cit 1 Burial 2 ☐ Cremation 3 Removal from State ikesville. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Licensee rao 140l 23a. Part Lenter the dis short, or heart failt Immed e Cause (Final disease or condition resulting in death) Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o Physician/Medical Examiner al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and use as the burial-tran Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Dobably 1 Tyes 2 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 No 1∐ Yes 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 1 🔲 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print) auva Hou 0 31. Date filed (Month, Day, Year) State 1 2008 0 730 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 334 Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3 Time of Death Physician Month Year Henber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lnion Memoria HMONE (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Months Days Min 1 M 2 K 227-38-9015 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar is and be notified at 1 □ 💢 🕏 2 🗆 No Funeral Director timore 10e and Numbe 10f. Zip Code 10g. Citizen of What Country? arble Hall . Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Tes a No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO HOT use retired) and Mental Hygiene.

Is marked other than dary (0-12) College (1-4or 5+) Fathe ddle, Maiden Surname) 18. Mother's Name (First, M. Be ပ္ Informant's Name/Relationship 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) Department of Health an Important: if item 27 Is any Injury or other trau 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death dving Immediate Cause (Final **Physician** pote ASIO disease or condition resulting in death) /Medical Due to Mas e consequence of): Examiner to (or as a consequence of): Sequentially list conditions, if any, leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burlal-transi PARR OI and Due to (or as a consequence of) attending physician for use as the burlal Box 68760 Physician/Medical law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 □ Yes 2 N6 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🖾 Natural 2 Accident 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOMOR

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32

Registrar's Signature

			For State	State of Ma	ryland / [Department of			-		-211115	3 3 3 '	35
			Registrar 1. Decedent's Name (First, Middle, La	ef)		Certificate of	Death		Date of De	Reg. No		3. Time of Death	1
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	Examin		4a. Facility Name (If not institution, giv	re street and number)	inoto	4b. City, Town,	or Location	of Death	Li		c. County of Deat	h	
	Funeral	7 1	5. Social Security Number 6. 5	Sex 7. Age	(In yrs. last bir	rthday) If Under 1 Yea Yrs. Months Days		24 Hrs. 8. Min.	Date of Bir (Month, Da	th y, Year	9. Birth Co 1908 Vir	hplace (State or Fore untry)	ign
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	yland h ow		10a. State 10b. County		10c. City, Tow							10d. Inside City Lim	
	e Ma Ba-f s	Director	Maryland N/A		Baltin							1 X Yes 2 □	NO
516	ith with the Maryland 23a or 28a-f show ust be notified at	ral Dire	10e. Street and Number 52 Hillvale Road			10f. Zip Code 21229				US	itizen of What Co SA		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 N			Yes or No an, etc.))-	14. Race - Ame Black, White Specify: Wh	e, etc.	
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and	d be filed intal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last Henry Lafaye		.son		18. Moth	er's Name <i>(Fi</i> .a	irst, Middle Blar			ams	
Baltimore, Maryland 2	2 should and Me is mark aumatk	ပ္	19a. Informant's Name/Relationship	(Type. Print)	I .	o. Mailing Address (Street				-		Zip Code)	
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Z O	Pages ent of l nt: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			ery, crematory or other p a-Park Ceme		9/27/0	8		•	Maryland	
att	permit. F Departm Importar any Injui		21. Signature of Funeral Service Line		-	22. Name and Add	lress of Facil	ity Loudo	n Par	k F	uneral H	ome	
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	Examiner		Sequentially list conditions.	b. Hy	parta	95100							
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68760,	icate be executed physician and the burial-transit	edical Exar	that initiated events resulting in death) Last	Due to (or as a	a consequence	of):							
_	rtificate ng physi as the l	Medi	IE ECMALC:			-				- 1			
P.O. Box	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknowh	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	h 3 ⊟Ectopic pregnai 5 ⊟ Other (specify)					23d. Date of de Month	livery Day Year	
	es that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death bu	it not resulting i	n the underlying cause	given in Part	1.				the cause of death	
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Division or Vital Records,	The la ate has page 2	Completed							24a. Was auto perf 1∐ Yes		death?	utopsy findings availa completion of cause	of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:)ther:	ce of Death (C					
or	Phys er this eral dii	To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28b.	Time of 28c. In	4 ⊔ N				6 □Other (Specially occurred)	ecify)	
ion	Attending r death. ector: After by the funer	atior	1 Natural 5 Pending 2 Accident investigation		Year)		/ork? □Yes 2□	□No					
Divis	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Hornicide determined		ry - At home, fa c. (Specify)	arm, street, factory, offic	e	28f.	Location City or To			ural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C			examination a	e, death occurred at the nd/or investigation, in m							
	To th within To th comp	Me	29b. Signature and title of certifier	12		29c. Lice	ense number	405		29d. D	Date signed (Mon	th, Day, Year)	
	5		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)	// (/ - //	. \)	
	Sta	ate	31. Date filed (Month, Day, Year)		ar's Signature	Co S	ports	and	500	740	al H	sopital	
	Regist	rar	OCT 0 1	2008	igas St	Marie							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200 AM Deritment 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town or Location of Death 4c. County of Death Examiner BA If Under 1 Year JOHNS NORKING BAYVIAN MEDICAL CONTE 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 □ M 2 🕱 F 94 217 34 5057 Director Maryland June 17. 1914 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heathh and Mental Hygiene, important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 🔀 No Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2019 Paulette Road 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 2 1 ☐ Yes 2 🗷 No Specify Specify. 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gift Rapper 9th Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanislaus Zebron Veronica Mikolzjoczyk 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Kavanagh / Daughter 408 Ben Oaks Drive West Severna Park, MD. 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/30/2008 Baltimore, Maryland Baltimore National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. namuan Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician KESPIKATONY HOUR /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation

Division of Vital Records, P.O. Box 68760, Il or Attending Physician: after death. Director:

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C

State

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) OCT 0 1 2008

3 ☐ Suicide

29a. Certifier

BRILLE

6 ☐ Could not be

JA8914

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

ress of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

4940 EASTERN AVENUE

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RES-000

2 🗌 No

BALTIMORE MU

28f. Location (Street and Number or Rural Route Number, City or Town, State)

REPTETHBER OF 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anthony J. Mikalajunas 2008 3:00 A. M September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab. Cen. Crofton Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 09/23/1917 **Funeral** Months Days Hours 1 X M 2 □ F 91 Director 214 14 7243 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, The Medical Evanilhar shust be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville Road 21114 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 و ک 1 ☐ Yes 2K No Specify. Specify: 3 Widowed 4 Divorced White Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Supply Officer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ignatious Mikalajunas Genevieve Salkauskas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet D Burkman Daughter 1302-B Scottsdale Drive Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD State Veteran Cem. 10/02/2008 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 mameroush 23a. Part 1. Enter the diseas — complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy a No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 LAN Other: 4 Hursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Uniural 2 Accident 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 31. Date filed (Month) egistrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Carolyn Dolores Nelson 9-29-2008 10.55P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Oakcrest Village Parkville Balto. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 🖺 F Months Yrs Director 2-5-1924 193-14-3883 84 <u>Pennsylvania</u> Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar must be motified at Md. Harford 1 ☐ Yes 2 No Directo Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 4105 East Baker Avenue USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: <u>8</u> Specify: White 3√ Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 'Give kind of work done' during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Rybarczyk ٩ Wanda Swankowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheri Whiting DTR. 4105 East Baker Avenue Abingdon, Md.21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph's 10-2-2008 Nottingham Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 10 years resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Box 68760 Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O.1 signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Vital 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 1NO Hospital or Attending Physician: '24 hours after death, Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🖪 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed sause of death (Item 23a) (Type, Print) Duther Bril

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

3016

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 28. Elizabeth 2008 4:30 PM Jane Niemyer September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Franklin Woods Nursing Center Rossville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🛣 215-54-0665 Yrs Director March 13, 86 1922 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant; If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; for items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, train-from Evanting or other traumatic event, train-from Evanting of Once. 1 ☐ Yes 2 🛣 No Director Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 410 Schotts Road by Funeral S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ^{2□No} 1945 1 ☐ Never Married 2 ☐ Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 □ Yes 2 □ Xo Specify. 3 XWidowed 4 ☐ Divorced 1946 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Joseph Bernard Smith Nellie Virginia Shoemaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey W. Niemyer (Son) <u>400 Schotts Road</u> Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/2 4 Dopation 5 Dother (Specify) Lawn Cemetery 2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cardiac or neach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atrial Fibrillation Several Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, buscass or in jury that initiated events Examiner Due to (or as a consequence of): Kpua Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by after death.

I Director, After this certificate has
In by the funeral director, page 2 should 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 ☐ Yes 2 **_____**10 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D0051349 1241 30. Name and address of person who complete d cause of death (Item 23a) (Type, Print) 9101 Franklin Square Drive Suite 205 Dr. Florence Deza Baltimore, MD 21237 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

OCT 0 1 2008

Maryland 21215-0036

Saltimore,

Box 68760.

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 🖰 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Victoria T:55AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore. Hospice - Northwest Hospital Kandallstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 216.10.934 Months Hours Min 1 □ M 2 X F 92 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Randallstown Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Millstone 21133 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Caucas an 1 ☐ Yes 2 X No ģ Specify 3 XWidowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book 12th grade vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zalavaious 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown MD 21133 32 Millstone Ortanzi Koad injury or other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 Removal from State Woodlawn, MD 10/01 08 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Valunn C. Greene Fundral SVCS any in 8728 Liberty Road Prindalblown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final end-stage cardiomyopathe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physiclan; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Year Day 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown cate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 2 110 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 6 Dother (Specify) Other: 4 Nursing Home 5 Residence Medical Certification: To 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 tural within 24 hours after death. To the Funeral Director: ♭ 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MSCINIPALISENIO D0057465 9/26/08

State

DCT 0 1 Registrar

N.S. Rajapaklemb

31. Date filed (Month, Day, Year)

25 Main St. , Suite 200, Reisterstown, ND . 21136. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

State Registrar 30. Name and address of person who cor

31. Date filed (Month

EDW

of death (Item 23a) (Type, Print)

32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 18:33 DARRYL HILLIPS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMORE If Under 24 Hrs. CENTER UNIVERSITY OF MARYLAND MEDICAL 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number Funerai 216-84-43 Usual Residence of Decedent Months Days Hours Min Director 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene, instural, or items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at any injury or other traumatic event, the Medical Evantiner must be notified at any once. 10a State 10h County 1 Tes 2 No Director timore Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian. Black, White, etc Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 o Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname Be 19a. Informant's N-me/Relationship (Type. 19b. Mailing Address (Stree Rural Route Number, City or Town, State, Zip Code, Method of Disposition 3 Removal from State 4 Donation 5 DOther (Specify) eture of Euneral Service Licenses 23a. Part F. Ehter the disease, or complications that caused the death. Do not enter the mode of Lying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LYMPHOMA Physician BURKITTS MELOUN /Medical Due to (or as a consequence of): Examiner HIV /AIDS UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 2 No 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTMORE MD DANIEL CLOTNICK SOUTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 2 55 M 1008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Jessup Howard County Howard County Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 23, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 65 217-42-8312 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Evantment must be notified at MD Howard Jessup 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20794 USA 8336 Darkwood Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Pastry Chef Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Unknown Charles W. Pease, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8336 Darkwood Ct., Jessup, MD 20794 Lou Ann Prosack 20a. Method of Disposition Place of Disposition (Name of demetery, crematory or other place) 20c. Location - City or Town, State ☐ Burjal 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Atlantic Crematory 9-29-2008 Glen Burnie, MD 22 Numeral Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician tricolm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) P.O.1 1 Yes 2 No 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 □Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \) (Specify) 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ather

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 | 3 4 4 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 8:35 AMM 2008 Andrew John Panzer 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kingsville, Maryland Baltimore 11605 Mohr Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Maryland 66 01/30/1942 Director 216-38-4301 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD Kingsville Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21087 U.S.A. 11605 Mohr Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White ò If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Workers is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Local 100 12 Sheet Metal Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Agnes Mohr Andrew J. Panzer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 11605 Mohr Road - Kingsville, Maryland 21087 Carol J. Panzer (wife) item ! 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I Department of Important: If it any injury or o once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/29/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6 A? 11750 Belair Road - Kingsville, Maryland 21087 000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jyeurs Star disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner create Sequentially list conditions as a consequence of Physician/Medical Examiner frank, leading to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi coronar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2010 page 2 s certificate 1☐ Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral After 5 Pending investigation Iniury 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident the f after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physician: within 24 hours af

To the Funeral D

completely filled in Hospital

the

death 1

within 72 hours after

Baltimore, Maryland 21215-0036

D

the

Medical

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

State

nd address of person who completed cause of death (Item 23a) (Type, Print)

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0 34 431

29d. Date signed (Month, Day, Year)

9125108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Registrar Continuate of Dodg.			10
Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of Death September	-Day 7, 2008	3. Time of Death 11:15pm
/Medic	al	Elsie H. Raver 45 Sacility Name (If not institution give street and number) 46 City, Town, or Location of Death	Берссивет	4c. County of Death	
Examin	er	4a. Facility Name (in Not institution, give stress and institution)		Carrol1	
		5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yo	9. Birth	place (State or Fore
Funeral Director		214-28-6095 Usual Residence of Decedent	June 26,	, 1916 M	place (State or Fore intry) D
MC II		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lin
-f sho	ro	MD Carroll Westminster			1 Yes 2
a or 28a.	Director	10e. Street and Number 1234 Washington Road 21157	10g	. Citizen of What Cou USA	intry?
ital Hygiene. id other than "natural", or items 23a or 28a-1 show event, the Modical Examiner must be nutified at	y Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In 1 Yes 2 No If Yes, Gree 1 Yes, G	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
'natural' Jical Ex	Completed by	3 Notioned 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16	b. Kind of Business/I	ndustry
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riygler other th	S	10	e (First, Middle, Ma		
ever	Be	A.J.	C. Arnold		
and Mental Hyglene. is marked other than eumetic event, ILEM	2	Francis M. Hoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			ip Code)
7 is r treur		Mr. Jesse Hall (Power of Attorney) 2525 Baltimore Blvd	d., Finks	burg, MD 2	21048
Department of Health and Menta Important: If Item 27 is marked eny injury or other treumetic er once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State		oc. Location - City or estminster	
partmen portant: y injury 2 <u>e</u> .		21. Signature of Funeral Service, Licensee 22. Name and Address of Facility, HAIGHT FUNERAL HOM PO Box 195 Sykesy			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause in each line.	ille, MD or respiratory arres	21784 st.	Approximate Interval Between Onset and Deat
ysician Medical aminer	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	st.	Interval Between
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evin Rouzer		State of Maryland / Department of Health 1- For State Certificate of Death	and Mental Hygiene	711118 3 1 3 L
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Month	
edical Exami	ner	Kevin Donnell Rouzer 4a. Facility Name (if not institution, give street and number) 4b. City, Town	n, or Location of Death	Pember 28, 2008 2230 hrs
		Johns Hopkins Hospital Baltimor	re	NA
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 2/3-94-09241 XM 2 F 29 Yrs. Months		e of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
any	П	Usual Residence of Decedent 10a. State 10b. County 10c. City Toyn or Location		10d. Inside City Limits
	to	Md N/A Baltimore 10e. Street and Number 0 0 10f. Zip Co		1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Direc	1517 Presstman Street	21217	USA
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, specify C	of Hispanic Origin? (Specify Yes Cuban, Mexican, Puerto Rican, et	
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than "	Be	Donnell Kouzer	18 Mother's Name (First, M	JAMPSON
D Shou shou and haric	ပ	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (19c + Rice Ampson (Nother) 1517	Ress tman St	reet BAIto Md 21217
S L S L		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of Di	1 10/, 1	08 LANS downe, Md
Baltimor permit. Pages Department of Important: If		21 Sign ure of Funeral Service Licensee 22. Name and Ad 33 Sign ure of Funeral Service Licensee 23. Name and Ad 33 Sign ure of Funeral Service Licensee 23. Name and Ad 33 Sign ure of Funeral Service Licensee 23. Name and Ad 33 Sign ure of Funeral Service Licensee 23. Name and Ad 33 Sign ure of Funeral Service Licensee 23. Name and Ad 33 Sign ure of Funeral Service Licensee 23. Name and Ad 33 Sign ure of Funeral Service Licensee 23. Name and Ad 34 Sign ure of Funeral Service Licensee 23. Name and Ad 34 Sign ure of Funeral Service Licensee 24. Name and Ad 35 Sign ure of Funeral Service Licensee 25. Name and Ad 35 Sign ure of Funeral Service 25. Name and Ad 35 Sign ure of Funeral Service 25. Name and Ad 35 Sign ure of Funeral Service 25. Name and Ad 35 Sign ure of Funeral Service 25. Name and Ad 35 Sign ur	. Fulton Ave	IR tuneral Home BAIto, Md 21217
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E / 4.0	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
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Box 68760, edeath certificate be the attending physici ed for use as the buri	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box ne death v the atte	Physi	1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying or		e. Did tobacco use contribute to the cause of death?
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Division pital or Attent ours after death teral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	ог	cation (Street and Number or Rural Route Number, City Town, State)
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be deached for use as the bh	ledical Cer	4 Homicide determined (Specify) Local Street 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tile (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my or	ime, date and place, and due to	N. Broadway, Baltimore, MD the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
To 1	Med	and manner stated. 29b. Signature and title of certifier 29c. I	License number	29d. Date signed (Month, Day, Year)
		attica Wignila - Oller	O.C.M.E.	September 29, 2008
M		Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD	21201
	State			
Regi	ગાહી	OCT 0 1 2008 Source De Source		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Robinson 1:20A M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Hospice - Northwest Hospita Kandalkstonii 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Min Months Days Hours 1 □ M 2 X F 212.20.3419 86 06/192 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinet must be rediffied at once. Baltimore MD 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Wicklow 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 □ Yes 2 1 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: ģ Specify: Back 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hivate 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (George Thomas Walker Mar 2 19a. Informan Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wicklow Road Baltimore MD 21229 Samuel Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 Removal from State Laurel, MD lanuland 10/03/08 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Jaughn Greene Pineral 21. Signature of Funeral Service Licenses Vauxh ndallstown MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear valure. List only one cause on each line. Immediate Cause (Final ASCVD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of Figure that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 1 Whknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate has 1 ☐ Yes 2 ☑ No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊡∕No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To after death. Director: After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9127/08 00057465 MSKAIRPOULLEMP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

N.S. Rajapakse, MD

31. Date filed (Month, Day, Year)

eisterstown

25 Main St. Suite 200

2008

32 Registrar's Signature

			For State Registrar	State of Ma	aryiand / Depa Ce	rtificate of L			No. 2008	31348
	Physicia	an	1. Decedent's Name (First, Middle, L	ast)				Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Thomas G. Reyno			4h City Town or	Location of Death	Septembe	r 28, 200 4c. County of Deat	
	Examin	er	4a. Facility Name (If not institution, g Future Care	ive street and number)		Reister			Baltimo	
	Funeral				e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry)
	Director		216-34-7666	1 K M 2 □ F	72 Yrs.	Months Days	Hours Will.	12/19/3	5 Mar	yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	f sho	ō								1 X Yes 2 □ No
	28a-	Director	MD n/ 10e. Street and Number	a	Balti	nore 10f. Zip Code		10g	. Citizen of What Co	untry?
3	23a o	a D	907 West 36st S	treet		212	11		USA	
	ems (Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	Ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
9	or it	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 🕦 I If Yes, Give		1 □Yes 2 No			Specify:	T. H
3	should be filed within 72 hours after death with the maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, I'm M-drail Evaning in unit be multified at		15. Decedent's	Year or Dates:	16a. Dece	edent's Usual Occup	ation	16	b. Kind of Business/	White Industry
ני	e in fina	Completed	(Specify only highest g	rade completed) College (1-4or 5	life.	kind of work done of DO NOT use retired	during most of work i)	ing		
7	d with	Com	12			Produce 1	Manager		Grocer	у
2	tal Hy tal Hy d oth	Be (17. Father's Name (First, Middle, La.	st)				e (First, Middle, Mai	iden Surname)	
7 2	z snould be filed within and Mental Hygiene. is marked other than aumatic event, II	ို	John Reynolds		T		Mary		24 T	7:- 0-4-1
	th and 7 is n traun		19a. Informant's Name/Relationship Mrs. Mary C. Hil			ing Address (Street) Maple Gro			., Marylan	
ע.	1 and Health tem 27 other tr	1	20a. Method of Disposition	ther / bib		osition (Name of ormatory or other place			c. Location - City or	
<u> </u>	permit. Pages 1 and 2 should be filled villed be permit. Pages 1 and 2 should be filled by beatment of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, If once.	П	1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State		re Cremato re Cremato	i	/08 B	altimore	Maryland
	permit. I Departm Importar any Injur once.	- 5	21. Signature of Funeral Service			2. Name and Addres			Funeral	
Ď	Depar Impor any Ir	1	Eugene)	(auto	n	3620 Wilk	ens Ave.	Baltimore	, Marylan	d 21229
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	d the death. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
one F	hysician		Immediate Cause (Final disease or condition	_ a(trinic (bstruct	ine Un	My ales	line	amin
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	and the same of th		7		
		ē	Sequentially list conditions,	b. Due to (or as	a consequence of):					
	uted d ansit	Examiner	n any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events							
<u>,</u>	an an	Еха	resulting in death) Last	Due to (or as	a consequence of):					
8/00,	ate be hysicii he bu	edical	•	d						
ĕ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:	00-16						
ָם מ	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnanc	ey .		23d. Date of de Month	livery Day Year
5	y the c	ysic	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknown	at time of death 5	Other (specify) _				
7.	ned by		Part II. Other significant condition	contributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
Hecords	quires an sign	d by	Ju	chele,				1 □ Yes	2 No 3 P	robably 4 Onknown
0	aw rec	Completed	(2)	resent	Vio	r		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
ř	The II	mo	n	A MARINE	0.0 [02]	4.1		performe	death?	_
VITAL VITAL	ertifica ctor, I	Be	25. Was case referred to medical examiner?		2000			th (Check only one)		
0	nysic this ce al dire	안	1 Yes 2 No		ent 2 ER/Outpatie		4 Nursing H		ce 6 ☐ Other (Spe	ecify)
	Ing F	ion:	27. Mann Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay, Year) 28b. Time Injury	Wor	ryat k? Yes 2 □No	28d. Describe how	injury occurred	
VISION	death death ctor: / the i	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 280 Place of In	jury - At home, farm, s		iles Z 🗆 NO	28f, Location (Stre	et and Number or Fi	iural Route Number,
2	after after Direct	Certification:	4 ☐ Homicide determine	building, et	tc. (Specify)	, ,,		City or Town,	State)	
	To the Hospital or Attending Prysician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			Physician: To the best						
	the He lin 24 the Full 124 the	Medical	one)	and manner st						
	vith voil	Σ	29b. Signature and title of pertifier	MD		29c. Licens	se number	290	d. Date signed (Mon 9/w/C	
			4	1	de este du la constant	Dulen)	1301		1104/0	
	2		30, Name and address of person w	no completed cause of o	death (Item 23a) (Type	/X39	8 Green	v Ta	00 1	1 2110 C
	Sta	te	31. Date filed (Month, Day, Year)	2. Regist	rar's Signature			- ()	1 0	1000
	Registr		OCT 0.1.20	18 Harris	15 100	Want of the second				

			- FOr	partment of Health and Mental ertificate of Death	Hygiene 008	31349
	Physici	an	Decedent's Name (First, Middle, Last) BERNICE MARGA	Mon Mon		3. Time of Death 1:20 A
	/Medic Examin		4a. Facility Name (If not institution, give street and number) GOLDEN LIVING CENTER	4b. City, Town, or Location of Death WESTMINSTER	4c. County of Dea	ath
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs. 8, Date	of Birth 9. Bi	rthplace (State or Foreign
	Director		Usual Residence of Decedent	4/1		NNSYLVANIA
	Marylar f show	tor	10a. State 10b. County 10c. City, Town or L MD CARROLL WESTM	INSTER		10d. Inside City Limits 1 ☐ Yes 2 No
	with the	Director	10e. Street and Number 441 OLD NEW WINDSOR RD.	10f. Zip Code 21157	10g. Citizen of What C	Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It man 27 is marked other then "naturat", or Rems 23a or 28a-f show other traumatic event. The Medical Examiner must be notified at	y Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 № 1 1 □ Yes 2 №	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et		ite, etc.
21215-0036	72 hours natural', ical Ex	sted by	3 XWidowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dece	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Busines	
121	within in itene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) DIETARY	HOSPITAI	
and ?	2 should be filed within and Mental Hygiene. is marked othar than aumatic evant. Its M	Be	17. Father's Name (First, Middle, Last) GEORGE RUDOLF LAND	18. Mother's Name (First, M		
Maryland	2 should be and Mental is marked c	T ₀	19a. Informant's Name/Reiationship (Type, Print) SON 19b. Mail	lling Address (Street and Number or Rural Route	Number, City or Town, State,	Zip Code)
	Health tam 27 other tr		20a Method of Disposition 20b. Place of Disp	HICKORY COVE DR., Coosition (Name of ematory or other place)	20c. Location - City of	30115 r Town, State
Baltimore,	permit. Pages Department of i Important: if its any injury or o		1 □ Burial 2 □ Cremation 3 □ Hemoval from State 1 □ Donation 5 ☑ Other (Specify) ENTOMBMENT EVER(FINKSBURG	
6	88 2 2 8		23a. Parti. Enter the disease, or complications that caused the death. Do not en	254 E. MAIN ST., WE	<u>_</u>	Approximate
	Pnysician /Medical		shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or et a onsequence of):	fent Fribure		Interval Between Onset and Death
	Examiner	ē	Sequentially list conditions, 1 any, leading to firmediate cause. Enter Underlying	puthy		1 yr
, 0	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	the varenter de	sun	25yn
68760,	ate the	edica	d. Colomica			974
O. Box	that the death certific ed by the attending p detached for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of d Month	elivery Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23s	a. Did tobacco use contribute 1 ☐ Yes 2 ☑ No 3 ☐ F	to the cause of death? Probably 4 □Unknown
Vital Record	The ate h page	Completed			autopsy prior to performed? death?	autopsy findings available completion of cause of
fVit	ysiciar iis certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Home 5	k only one) ☐ Residence 6 ☐Other (Sp	pecify)
ion of	ding h. Afte fune		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		scribe how injury occurred	
Division	ai or Atten s after deatl if Diractor: id in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Loca City	ation (Street and Number or I or Town, State)	Rural Route Number,
	e Hospitai or 124 hours afte a Funeral Dira letely filled in b	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.			
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo.	nth, Day, Year)
,	10		30. Name and address of person who completed cause of death (Item 23a) (Type	D25443 e, Print)	4129/2	£ € 8'
	Sta	ite.	JOHN W. MIDDLETON, MD, 3337 VI 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ICTORY ST., MANCHES	STER, MD 211	02
\$.	Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	metho		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 12:00 PM nmor 29, eptembei 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner toward Junder Hil olumbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 1 M 2 □ F ountry 172-22-4874 Yrs. Kennsylvanua Director Notionbel Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 Types 2 No ed other than "natural", or items 23a or 28a-f shevent, the Widtest Evan, increment or puffed Director unbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number +711 2104 54 Funeral 12. Was Decedent Ever in U.S. Armed Porces? 1 Dres 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. MINISTE marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evance. Shina 1 mmon 9 Marion ٩ unil 19b. Mailing Address (Street and Number of Rural Route Number, 1924 Informant's Name/Relationship (Type. Print) 164 Columbia, MD immens - Wite 58 bb armen ihunde 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 20 Creimton altimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Funeral Batto MD 2126/ Hahts Hue 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** Non Small-Cell /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical ed by the attending detached for use as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 HInknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 After this certificate has been sign funeral director, page 2 should be 3 Probably 4 ☐ Unknown Emphysema Yes 2 🗌 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
Yes 2 □ No Arten Disease 24a. Was an autopsy performed? Yes 2 No Dementia Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 23679 10-01-2008

State

Registrar

JOW WIT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2008 28 Thomasena /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If got institution, give street and number) Examiner 4669 FOUIS Himou If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 Carolina Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show must be notified at 1 PYES 2 No Himal by Funeral Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 5439 21215 rairlawn 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Blac Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Mplayed eanes 18. Mother's Name (First, Middle, Maiden Surname) or other traumatic event, 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any injury or other trau once. 3alto. Fannie 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 3 □Removal from State ■ Burial 2 □ Cremation 3/08 Dietus 101 4 Donation 5 Dother (Specify) 22. Name and Address of acility Ho me Howell 21. Signature of Funeral Service License Balto. MD 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final S CVD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Cause (Disease of injury that initiated events resulting in death) Last burial-transit **6** g The law requires that the death certificate be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed certificate has 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**□**₩6 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 1 ☐ Yes this funeral (27. Mann of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury Fo the Hospital or Attending † Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide after (4 ☐ Homicide the Funeral Dimpletely filled in within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Wedical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 Nova 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 00 8 SMUTH **Physician** OHNNIE /Medical 4b. Sity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner OSPITAL ACTIVIORE 9. Birthplace Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🗶 F Months Days Hours AR 265.84. ON Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at Baltimore 1 Yes 2 No Pikesville Completed by Funeral Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21208 IJSA 7905 - B Crisford Place permit. Pages 1 and 2 should be flied within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, If a Mental once. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Red Bud College (1-4or 5+) Elementary/Secondary (0-12) Equipment Operator Excavation 12th orade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McDonald Marie Johnn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crisford Dlace Pikesville MD 21208 A. Smith ames /Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/30/08 Baltimone, MD Greenmount Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugho C. Greene Tuperal SVCS aun 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the insease, or complications that caused the death. Shock, or he intailure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2475 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be execute burial-trans Due to (or as a consequence of) Box 68760, physician Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) P.O. ed by the detached f 9 Unknown 9 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has t autopsy 2 No Division of Vital 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

PAUL

ST.

Registrar's Signature

PLACE BAUTINONE

21212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** September 27,2008 9:00 A Leonard Schulman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 5600 Wisconsin Ave. #1406 Chevy Chase If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1 X M 2 F 88 DC 02/25/1920 578-05-4800 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show ir than "natural", or items 23a or 28a-f shoothe Woolgal Examinet must be notified at 1 ☐ Yes 2 X No Director MD Chevy Chase Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20815-5600 Wisconsin Ave. #1406 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: W W II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No ģ Specify: White 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Consulting permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other trainmais. Elementary/Secondary (0-12) College (1-4or 5+) **Business Consultant** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Feldman Harry S. Schulman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1276 West River Rd. Shady Side, MD 20764-Steven Schulman/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Sep 30 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, Maryland 2008 4 ☐ Donation _ 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral & Cremation Serv
933 Gist Ave., Silver Spring, 21. Signature of Funeral Service Licens M00382 20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) 3 MONTHS **Physician** METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transi Exami and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No page 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 5 Pending 1 □Yes 2 □ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Box 68760 P.O. of Vital Records, Division

Baltimore, Maryland 21215-0036

State

KOGERS

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

5530 WISCOUSIN AVE #1400 CHEVY CHASE M.Da 20815 32. Registrar's Signature

50030

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medidal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

29a. Certifier

29b. Signature and title

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Shivers /Medical Walter A. 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner tal Greneral HMOVE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F 85 Director 12/15/1922 AZ 527-20-1167 Usual Residence of Decedent 10a. State 10h County 10c City Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f shov any Injourant: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examination and the modified at 1 ☐ Yes 2 No Director MD Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21901 USA 168 Bridgewood Avenue death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: W W ☐ 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. <u>à</u> 3 ☐ Widowed 4 🔀 Divorced WWII White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Construction Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Campbell မ Walter Shivers Jessie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nate Shivers/Son 1574 Carpenters Point Road Perryville, MD 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Maryland 21286 Baltimore Approximate Interval Between Onset and Death 23a. Part 1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Preumonia with Bilateral Pleural Effusion Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tra Due to (or as a consequence of) physiciar The law requires that the death certificate be Physician/Medical as the attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month Year 5 Other (specify) been signed by the should be detached f 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed? 1 □ Yes 2 1 No certificate 1 ☐Yes 2 ☐ No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day, Year) Injury

P.O. Box 68760, Division of Vital Records.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral s after death.

completely Registrar

State

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person

31. Date filed (Month, Day, Year) 32. Registrar's Signature

08-07323 Sarah Stuart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 31355

	For State of Maryland / Department of nea	th	g. No.
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month September	3. Time of Death
al Examiner	Sarah Jane Stuart 4a. Facility Name (if not institution, give street and number) 4b. City.	Town, or Location of Death	4c. County of Death
	Confils Flopkins Bayview Medical Center	imore	Chatagoria (Chatagoria
Funeral Director	231-08-2091 1 48 Yrs. Mon		/1960 Solution (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) DC
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
★ . 1	TN Washington Gray		1 Yes 2 No
5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Completed by Funeral Director	10e Street and Number 307 Silver Oak Dr 37	ip Code 10 U	g. Citizen of What Country?
or items 23	1 November 1 1 Norman 2 Armed Forces? If Yes, spe	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
ter dea ", or it er mus	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:	Specify:White
ours after attental" samine ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu	al Occupation (Give kind of work done vorking life, DO NOT use retired)	16b. Kind of Business/Industry
5-0036 led within 72 hour Hygiene. I other than "natu the Medical Exau	Elementary/Secondary (0-12) 2 College (1-4 or 5+) Director	:	Computer AOL
	17. Father's Name (First, Middle, Last) unk Stuart	18.Mother's Name (First, Middle, N Susan Cox	
O 성 전 12 12		ver Oak Dr, Gray,	
ore, MD ss I and 2 sho of Health and If item 27 is her traumati	20a. Method of Disposition 20b. Place of Disposition (N	lame of cemetery, Date	20c. Location - City or Town, State
Baltimore, ocmit. Pages I a Department of He Important: If ite injury or other tr	1 Burial 2 Cremation 3 Removal from State crematory or other plan 4 Donation 5 Other Specify: Chesapeake	$C_{rem} = 10/3/2008$	Beltsville, MD
Baltimor permit. Pages Department of Important: If injury or othe	21 Signature of Funeral Service Licensee 22. Name a	nd Address of Facility CAFA/Ster	ohen D Lohrmann PA
M 링스트트 Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod	Green Pastures Dr	Towson, MD, 21286
Medical ∠xaminer ō	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate a. Complications of therm Due to (or as a consequence of): b. Due to (or as a consequence of):	al injuries	Death
ed nisit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
'60, sate be execut physician and he burial - tra	X UNPENDED AMENDED 23a,PII,2/,28a-f,	perME, G884 10/22/0	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Exherical control or the property of the completed by Physician/Medical Exherical controls.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 2 Set I yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (\$ g Unknown		23d. Date of delivery Month Day Year
P.O. By that the de gned by the detached f	Part II. Other significant conditions contributing to death but not resulting in the underly	mig sadds girtainin airti	obacco use contribute to the cause of death? s 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact errification: To Be Completed by P	Cirrhosis of liver	24a. Was	an 24b. Were autopsy findings availab
Rec The la icate hi page 2		1 ✓ Yes	
ital Recition: The sector, page	25. Was case referred to medical examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only one) DOA Other Nursing Home 5	Residence 6 Other:
ing Physi After this funeral di	27. Manner of Death 28a. Date of Injury 28b. Time of Injury		how injury occurred t was victim of
ion (tending eath.	1 Natural 5 Pending (Month, Day, Year) 2 X Accident Investigation 8/14/2008 2:30 am	1 Yes 2 X No campfin	re
Division o spital or Attending ours after death. neral Director: After filled in by the func	3 Suicide 6 Could not be determined (Specify) campground	or Town, S	Street and Number or Rural Route Number, C State) Site #162 Hossack onia PA
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and due to the cause my opinion, death occurred at the time, date	and place, and due to the cause(s)
) h	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 27, 2008
0/2014	30. Name and address of person who completed cause of death (item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Bo	altimore, MD 21201	
State	22 Manietrario Cignoturo		

Amend 20b, perFH G884 10/15/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan			of Health a of Death		giene Reg. No.	008	31356	5
b	Physici /Medic		1. Decedent's Name (First, Middle, Last) GWENDULYN STRAND 2. Date Moral Moral No. 10 No. 1							OX	3. Time of Death	M
***************************************	Examin	er	4a. Facility Name (If not institution, give str ANNE ARUNDEL MEDIC. 5. Social Security Number 6. Sex	last birthday)	•	wn, or Location of APOLIS (ear If Under 2:		4c. County of Death ANNE ARUNDEL Birth 9. Birthplace (State or Foreign				
200	Funeral Director			M 27 F 66	Yrs.		Pays Hours	Min. (Month, Da MAY 5,	y, Year)	PA	try)	
ر ام	be filed within 72 hours after death with the Maryland Hygiene. Hygiene, or teme 23a or 28a-f show of other than "natural", or teme 23a or 28a-f show event. The Medical Examiner must be notified at	d by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NC HALIFAX ROANOKE RAPIDS 1∑ Yes 2 No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
			203 BARNWELL AVENU	E 2. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		278 Was Deceden If Yes, specify	370 t of Hispanic Orig Cuban, Mexican, I No Specify:	in? (Specify Yes or No Puerto Rican, etc.)	USA	4. Race - Americ Black, White, Specify: BLA	an Indian, etc.	
	d within 72 h giene. or than "natu the Medica	Completed	15. Decedent's Educa (Specify only highest grade Efementary/Secondary (0-12)	ation completed) College (1-4or 5+) YRS	(Give life.	DO NOT use	done during most			d of Business/Ind		
	should be filed nd Mental Hygi i marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) THELMAR McNAIR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre					18. Mother's Name (First, Middle, Maiden Surname) NAOMI LITTLEJOHN t and Number or Rural Route Number, City or Town, State, Zip Code)				
	is 1 and 2 s of Health an item 27 ls i other traus		MARY A. MULLEN / S 20a. Method of Disposition	ISTER	203	BARNWE]	LL AVENUI	E ROANOKE	RAPI		27870	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic events.		1 Burial 2 MCremation 3 Removal from State 4 Donation 5 Other (Specify). METROPOLITAN CREMATORY 10/6/2008 ALEXANDRIA, VA 21. Sinatu of Fundial Service Lightnese 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 20746									
death certificate be executed (E)	Physician /Medical Examiner	Medical Certification; To Be Completed by Physician/Medical Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. Listonly one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. WING METASTATIC CABREAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
	å ÷ =		that initiated events resulting in death) Last Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy									
	that the death certific ed by the attending p detached for use as		in the past 12 months? 1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Day Year	7
Records,	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
	in: The law ificate has l or, page 2 %		25. Was case referred to medical				26 Place	24a. Was auto perfo 1 Yes of Death Check only	psy ormed? 2.00 No		psy findings availa mpfetion of cause 2 No	
	Attending Physician: Ir death. ector: After this certific by the funeral director,		examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? M 1 Yes 2 No				sing Home 5 Resi	g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
			29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
	->-0		30. Name and address of person who cop	Defeted cause of death (Iter	п 23а) (Туре,	Print)	2143	8 way Anno	Ser	tember	24,200	8
	Sta Regist		MICHAR J. Call 31. Date filed (Month, Day, Year) OCT 0 1 200	GNT W 4	ature	EX ENSI	E Hight	way (-) NOV	HOLI	SINDZ	1401	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 19:00 11M 2008 ARRIETI 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA ttospita Baltimone Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Funeral Months 1 □ M 2 🗷 F 212:28:1639 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Director MD Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 11SA tvenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1,4or 5+) Elementary/Şecondary (0-12) Childcare Provider 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Knight towler thnie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 Powhatan Avenue Apt. 1E Balto, MD 21216 Phyllis East 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park Windson Mill 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Voughn C. Greene Funeral Srvcc 22. Name and Address of Facility Road Randallstown MD 23a. Part 1. Ent f the i isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 yEORS /Medical Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) NIERSTITIAL burial-tran Hospital or Attending Physlcian: The law requires that the death certificate be exect Due to (or as a consequence of): Box 68760, Physician/Medical for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Yes 2 No 9 Unknown in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 Yes 3 Probably 4 Unknown 2 🗀 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a Was an autopsy perform Yes 2 ERTENSION 2 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 1 🔲 Inpatient this s after death. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 \square No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the date of the da 29a Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

01

2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:00P M 09 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Autumn Blaze Court Woodstock Howard If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Min. Year) Months Hours 1**X**M 2□F 247.60.3108 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified Howard 1 ☐ Yes 2 No Woodstock Director 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no one. Autumy USA Blaze 21163 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 13ack 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Army Ward Master 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a, Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Court Moodstock Baze 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/02/08 Crownsvilld, MD nownsville 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughn C. Greene Fundal SCS 8728 Liberty Road Randallstown MD 21/33 21. Signature of Funeral Service Licensee Vaush Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the ducth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LEUNS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical ast attending p for use as IF FEMALE nse if yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown has been sign Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate ha autopsy performe death? 1 ☐ Yes 20 No 2 No 1□ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 😝 No 卢 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home SE Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death.

I Director: A

d in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar MCYARL PURE/ JYBVMC Y
31. Date filed (Month, Day, Year) 2008 32. Registrar's Signature

30. Name and address of person who completed ca

1940 ENTERY

m 23a) (Type, Print)

DHMH 17 Rev 1/2001

Physician

Be Completed by Funeral Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please	Type or Prin					-			
For State Registrar	State of Ma	•	epartment of Certificate o				eg. No.	2008	3 3 3 5
. Decedent's Name (First, Middle, La	,	l C+	11 Cm			Date of Dea Month	Day	Year	3. Time of Death
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a. Facility Name (If not institution, give		1	4b. City, Town					ontgon	
Washington Adver		.ta⊥ e (In yrs. last birtl		koma P	ark r 24 Hrs.	8. Date of Birth		9. Bi	rthplace (State or Foreign
	- T-		rs. Months Day	/s Hours	Min.	8. Date of Birth (Month, Day Feb. 13	, Year) , 19	41 Vi	rginia
a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
aryland N/A		Balt	imore						1 X Yes 2 □ No
e. Street and Number		L	10f. Zip Cod	е			l0g. Citiz	en of What C	ountry?
3560 S. Hanover	Street			21225			U	.S.A.	
. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify C	of Hispanic O	rigin? (Spe	ecify Yes or No- Rican, etc.)	1.	4. Race - Am Black, Whi	nerican Indian,
1 ☐ Never Married 2 X Married	1 X Yes 2 □ No		1 Ves 2X No Specify:					Proposition	
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	Viet Nam	, 2.00					· · · · · · · · · · · · · · · · · · ·	White
15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Oc (Give kind of work do: life. DO NOT use re!	ne during mo	st of worki	ing	16b. Kin	d of Business	s/Industry
Elementary/Secondary (0-12)	College (1-4or 5		Owner	irea)			Ar	chery	Range
12th Father's Name (First, Middle, Lasi	f)	1	O WILCI	18. Moti	ner's Name	(First, Middle,			
. Fauters Haitle (First, Mildure, Eds)	Henry Tayl	lor Steg	a11	15. 1100		lma Juar			
a. Informant's Name/Relationship			Mailing Address (Stre	net and Num					Zin Code)
Joan M. Stegall			Archwood		-		-		and 21061
a. Method of Disposition	/ WIIC		Disposition (Name of y, crematory or other)			Date			r Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			y, crematory`or other p Hill Cemet	i	09/27	7/2008	Balt	imore	, Maryland
I. Signature of Funeral Service Lice	nsee	who	22. Name and Ad						ce, P.A. ryland 21225
3a. Part 1. Enter the disease, or long shock, or heart failure. List only mediate Cause (Final isease or condition esulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or Injury lat initiated events southing in death) Last	a. Due to (or as b. Due to (or as		st itis	201	<u>K</u>	latic	'n		Interval Between Onset and Death
FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal death t time of death	5 Other (specify	")		220 Did to		3d. Date of d	Day Year
rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 □ Yes 2 ▼ No 3 □							Probably 4 Unknown		
						24a. Was autor perfo 1 □ Yes		prior to death	autopsy findings available o completion of cause of ? es 2 □ No
Was case referred to medical examiner?	Hospital:				ce of Deat	h <i>(Check only o</i>	ne)		
1☐ Yes 2 No					ome 5 ☐ Residence 6 ☐ Other (Specify)			pecify)	
7. Manner of Death ↑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		njury \	Work?		28d. Describe how injury occurred			
3 Suicide 6 Could not be determined		ury - At home, far c. (Specify)	m, street, factory, offi	ce		28f. Location (S City or Tov	Street and In, State)	Number or	Rural Route Number,
	thysician: To the best iminer: On the basis of and manner st	of examination an							
9b. Signature and title of dertifier	M	~	29c. Lic	ense number					nth, Day, Year) 24 2068
D. Name and address of person who	completed cause of C	leath (Item 23a) (Type, Print) 3	00(Hos	girald	W- 1	Chev	24 2008 edy 2078:

State

SAM A 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAM AFKham- Ebrahimi 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Dolores R. Schmidt 5:10 P. September 26, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1003 Dumbarton Road Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🗓 F 213 18 3296 88 1920 May 12. Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie Marvland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 U.S.A. "natural", or items 23a 1003 Dumbarton Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ò Specify: White 3 x Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be August Quasky Loretta McMahon ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Darlene Hairsine / Daughter 1003 Dumbarton Road Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 09/30/2008 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee namudiski 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** emen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ar accidents be executed Due to (or as a consequence of): and burial-tran that initiated events resulting in death) Last physician at the burial-Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No the th Ö is been signed by the should be detache 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Mell wow a24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 1 □ Yes 2 INO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 291h 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 🛴 amader 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar 2008

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michael Wolfgang Schrodt 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) . Town, or Location of Death ware. Sec If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 1**X** M 2 □ F Days Hours 51 218 64 4260 Maryland 10/01/1956 Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Baltimore Essex Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21221 U.S.A. 303 Maple Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married Yes 2 Yes, Give 2 □ No 1 ∐Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: Viet Nam White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 12th Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hans Schrodt Nellie Thornhill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Altheas Schrodt / Wife Essex, Marvland 21221 303 Maple Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 10/01/2008 | Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway amerowsky 23á. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequince of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Idennia 1 Tyes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 5 No ension 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician/Medical

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State Registrar

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, it a Medical Examination must be notified at

permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic event

Physician

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Examiner

attending physician and for use as the burial-transit

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page 2 should

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law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

Hospital or Attending Physician:

death.

within 24 hours after death To the Funeral Director: filled in by the

 $\mathcal{M}_{\mathcal{A}\mathcal{C}} = \mathcal{L}\mathcal{M}_{\mathcal{L}}$ Maryland 21215-0036

Baltimore,

Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I.

25.(Was ase referred to medical examiner?

27. Manner of Death

29a, Certifier (Check only one)

🔂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Mg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

anklin Square

09.29.08

Year)

5. NADIGER

DHMH 17 Rev 1/2001

			For	State of Ma	arylan				and Mental	Hygie	ne	8 31362
			1 - State Registrar			Cer	tificate of	Death			No. 4 U U	
	Physici	an	1. Decedent's Name (First, Middle, La	,					2. Date Mont		Day Ye	ar 9:55 A M
*	/Medic		Thelma Taylor S 4a. Facility Name (If not institution, given				4b. City, Town, o	r Location o		~(4c. County of D	
M.	Exami	lei	Coristal Haspico	at the L	ake		Salis	huau			Wican	NICA
	Funeral		5. Social Security Number 6. S	Sex 7. Age		ast birthday)	If Under Year Months Days	If Under 2	24 Hrs. 8. Date Min. (Moni	h, Day, Ye	ar) 9.	Birthplace (State or Foreign Country)
	Director		221-18-0405 Usual Residence of Decedent	- W ZA	76	Yrs.			Sept	9, 19	932 De	elaware
	yland how		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	e Mar Ba-fsl	ctor	MD Wicomi	co		Salisb	ury					1 □ Yes 2√∑ No
	vith th	Funeral Director	10e. Street and Number	D 1			10f. Zip Code	010	0.1	10g.	Citizen of What	Country?
	eath v	era	28451 Old Quantion	12. Was Decedent E	Ever in U.S	S. 13. V	Vas Decedent of H	2180		or No-	USA 14. Race - A	merican Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Modical Evaning must be rectified at once.	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 21 N					gin? (Specify Yes , Puerto Rican, etc	C.)	Black, W	/hite, etc.
21215-0036		d by	3 ☐ Widowed 4 🏿 Divorced	If Yes, Give Year or Dates:			□Yes 21XINo	Specify:			Specify: white	
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DG-	e filec al Hyg I othe went,	Be C	17. Father's Name (First, Middle, Last			<u> </u>			r's Name (First, M		den Surname)	
\ <u>X</u>	ould b Ment Markec Markec	2	William Flemmi			1			ence Kra			
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Debra L. Cathell						r or Rural Route I Road Sa		•	te, Zip Code) 21801
- ē.	t Heal f Heal tem 2 other		20a. Method of Disposition	daugneer	20b. P		sition (Name of patory or other place		Date		Location - City	
) 6	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other, (Special		6	emetery, cren	natory or other pla	ce)				
Baltimore,	permit. Departn Importa any Inju		21. Signature of Funeral Service Licer Ronal d 8	Wade ADire	ctor	22 S.t	Name and Addre	ess of Facility	y pard 655	W. Ba	altimore	Street
	20 E # 9		VIMMAN	ace		Ba	ltimore,	MD 2	21201			
			23a. Part I. Enter the discusse, or come show or heart failure. List only Immediate Cause (Final	one cause on each lin	the deatr ie.			_				Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. BND STE			-BS71UZ	. Has	ART F	AILU	ME	
	Examiner		Cognomically list appolitions	h.								-
	ed sit	iner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or ear	a consequ	lerice ut):						i i
•	execut and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequ	uence of):						
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical E		_ d								
99	ng ph as th	Medi	IF FEMALE:									
Вох	eath certific attending p for use as	jan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 🗀 Fetal	death 3	Ectopic pregnanc	Су			23d. Date of Month	delivery Day Year
P.O.	at the de by the a tached i	Physician/Me	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time or a	eatn 5∟	Other (specify) _					
σ.,	ires that signed b		Part II. Other significant conditions	contributing to death bu	ıt not resu	ulting in the ur	derlying cause giv	ven in Part I.	23e.	Did tobac	co use contribut	te to the cause of death?
Records,	w require been sig should b	Completed by								1 ☐ Yes	2 No 3□	Probably 4 Unknown
ecc.	e law r has be e 2 sh	ple							24a.	Was an autopsy	prior	e autopsy findings available to completion of cause of
E F	ician: The l certificate ha ector, page								10	performed Yes 25		
of Vital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 160	Hospital:		ED/Outration	Oth	or:	of Death (Check		- 0 Floring	
0	ding Phys h. After this funeral dii	n: To	27. Manner of Death	28a. Date of Injur	ry	28b. Time of	28c. Inju	4 🗆 Nu	rsing Home 5 28d. Des		njury occurred	Specify)
ior.	endin sath. or: Aff he fun	atio	1. Matural 5 Pending investigatio		i, rear)	Injury		k≀ Yes 2□1	No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inju building, etc	ry - At ho . (Specify	me, farm, stre	et, factory, office		28f. Loca City	tion <i>(Str</i> ee or Town, S	t and Number o tate)	r Rural Route Number,
	spital ours a neral [29a. Certifier 1 Certifying Pl	nysician: To the best of	of mv kno	wledge, death	occurred at the ti	me. date an	d place, and due	to the caus	se(s) and manne	er as stated.
:	To the hospital or Attending Py within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral.	edical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examina	tion and/or in	estigation, in my	opinion, dea	th occurred at the	time, date	and place, and	due to the cause(s)
	Vithii Cong	ğ	29b. Signature and title of certifier				29c. Licens	se number		29d.	Date signed (M	lonth, Day, Year)
			100				100		410			-6/07
			30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, I	Print)	7. ~ 1	771 6	Hin	71200	268150
	Sta	ite	31. Date filed (Month, Day, Year)	32/ Registra	ar's Signa	ture		7 1	133 3/	3 23 3	my u	V) -1 C C C
	Registr		OCT 0 1 20	08 Registra	, to	1500	are of					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2008 28, Sept 4:15 Maxine Tribby /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 901 Kings Bridge Terrace Mt. Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 4 23 1 25 1 9. Birthplace (State or Foreign Country) PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 213-56-8710 57 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryl ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shury or other traumatic event, If a Medical Evanther must be notified a 1 □Yes 217 No Director MD Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 901 Kings Bridge Terrace 21771 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes ANNO If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Crowell & Baker Co. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Rizzo Maxine Naatz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 901 Kings Bridge Terrace, Mt. Airy, MD 21771 James Tribby/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory 9/29/08 Winfield, MD 21. Signature of Funeral Service Licenses Burrier and Address of Facility Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. P. rt 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or neart failure. List only one cause on each line. Onset and Death Imme lete Cause (Final disease condition resulting in death) **Physician** rohusi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Ö 9 I Unknown 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Residence 6 Other (Specify) Hospital: 1 Yes 2 TH6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending To the nospried within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral Director of t investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

Ihomas

Name and address of person who completed cause of death (Item 23a) (Type, Print)

650

gistrar's Signature

Sh

OCT 0 1

31. Date filed (Month, Day,

			For State Registrar		Stat	te of Ma	ryland / L	-	tment o <i>ificate d</i>			Ment		jiene leg. No.	$-2 \mathrm{n}$	08	3136	L
	Dhysisi	0.0	1. Decedent's Nam	e (First, Midd	dle, Last)				٠				ate of Deat	th Day	,	Year	3. Time of Death	_
	Physici /Medio		Dorothy										8 10:10A	VI				
1	Examir		4a. Facility Name (4	4b. City, Town, or Location of Death					4c. County of Death								
	-		Holy Cr						Silver Spring								-	
۱	Funeral Director		5. Social Security N	0636	6. Sex 1 □ M 2 \$		(In yrs. last bir		If Under 1 Ye Months Da		der 24 Hrs rs Min.	. (N	ate of Birth fonth, Day, L1/29	Year) /19	30	9. Birthpl Count OH	lace (State or Forei try)	gn
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	or 2	Ö.	10e. Street and Nu	mber					10f. Zip Cod	le			1	l0g. Cit	izen of W	hat Count	ry?	
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9	filed Hygi other	ပို	17. Father's Name	(First, Middle	, Last)					18. M	other's Na	me (First	t, Middle, I	Maiden	Surname	e)		_
an	d be ental ced o	o Be	James I							s	tella	Rae	Glane	cy		,		
$\overline{\geq}$	should mari	입	19a. Informant's N			t)	19b	Mailing	Address (Str	eet and Nu	mber or R	ural Rou	te Numbei	r. City o	r Town. S	State. Zio	Code)	
S	nd 2 sulth all				Daughter	7			Honey									
ē,	tem tem		20a. Method of Dis	position			20b. Place of cemeter				1	Date				City or To		
Baltimore, Maryland	Pages ment or ant: If i		1 ☐ Burial 2, 4 ☐ Donation		3 ☐ Removal Specify)	from State			tory or other ke Cre		Y	Sep 200	25 8	Ве	ltsvi	lle,	Maryland	
Balt	permit. Depart Import any Inj		21. Signature of Emeral Service Licensee A0(533) 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland								and 2	0010						
			23a. Part 1. Enter t	he disease, d	or complications	that caused	the death. Do								laryr	and 2	Approximate	
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4	Examiner		Sequentially list conditions b. Acute Myccardial Infarct															
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Records,	w requires that been signed should be de	þ	Part II. Other signi	ficant condit	ions contributing	g to death bu	t not resulting ir	the unde	erlying cause	given in Pa	art I.	2					ne cause of death? ably 4 🛣 Unknow	vn
SCO	aw re	olet										2	4a. Was a		24b. V	Vere autor	psy findings availat	le
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of Vital	sician: The certificate irector, pag	ابها	25. Was case refer	red to medica	al	····				26 P	lace of De		☐Yes :			□Yes	2 LINO	_
>		To B	examiner? 1 ☐ Yes 2 🔀	No	Hospital:	1 X inpatier	nt 2 ER/Ou	tpatient	3□ DOA	Othor:			Reside		6 □ Othe	er (Specifi		
	ding Phys h. After this funeral dii		27. Manner of Deat	ħ		Date of Injur	v 28b. 1	ime of		njury at Vork?	1 rear sing i	_	escribe ho				<u>′/</u>	_
ion	ndin th.:: Aft	ţį	1 Natural 2 ☐ Accident	5 ☐ Pendi invest	ng tigation	(Month, Day,	rear) II	njury		vork? I∐Yes 2	No							
Division	or Atte ifter des Director in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deter	not be mined 28e.	Place of Injui	ry - At home, fa (Specify)	m, street	t, factory, offi	ce		28f. Lo	ocation (St ity or Town	treet an n, State	nd Numbe	er or Rura	l Route Number,	_
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier (Check only	1⊠ Certify	ing Physician:	To the best o	f my knowledge	, death o	ccurred at th	e time, dat	e and plac	e, and d	ue to the c	cause(s) and ma	nner as s	tated.	
	thin 24 the Fu	Medical	one)	title of certific		the basis of I manner stat	ed.	u/or inves		ny opinion, ense numb		urred at					o the cause(s) Day, Year)	
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	5		30. Name and addr	ess en person	n who completed	d cause of de	ath (Item 23a)	Type, Pri		<u> </u>	<u>. T</u>			09	143/	2000		
	9				ngstack.	-				ver S	Sprine	g. M	D 209	906				
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	Registr	ar	0	CT 0 1	2008	At man	11	Prove !	A. 8									

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For amend #16a Fer Hi G884 16/789	artment of Health and Mertificate of Death		ene g. No. 2008	3 3 1 3 6 5
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Earl Lewis Walter	4b. City, Town, or Location of Death	09	26 2008	5:45 PM M
	Examir	er	4a. Facility Name (If not institution, give street and number)	7	4c. County of Deat		
	Funeral		Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	Baltimos 9. Birt	hplace (State or Foreign
	Director		215-03-9306 1 [™] 2□ F 88 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 02/10/19	20 Mar	untry) Vland
	ри >		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or L.			-	
	laryla sho	ō	, , , , , , , , , , , , , , , , , , , ,				10d. Inside City Limits 1 ☐ Yes 2 No
	the N	rect	MD Baltimore Kingsvil	10f. Zip Code	10	g. Citizen of What Co	
Ė	3a or	<u>E</u>	10832 Raphel Road	21087		U.S.A.	,
р.п	death	Funeral Director		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Ame	
5 %	after or ite	/ Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 No Specify:	Hican, etc.)	Black, White	
5:45	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Than "natural", or items 23a or 28a-f show ent, The Madical Evaninar must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:		ite		
	n 72 l	olete	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) LOWET	ing 1	6b. Kind of Business/	Industry
2008	withi	E O	Elementary/Secondary (0-12) College (1-4or 5+)	wer Grower	l B	lomestead I	Flower Gdns.
2 , br	e filed al Hyg othe vent,	Be Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, M		
SEPTEMBER 26, 2 altimore. Maryland	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Important of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maddeal Enaminer must be notified at once.	70 E	Lewis Christian Walter	Selma S	Schwartz		
R lar	2 sho			ing Address (Street and Number or Rur			Zip Code)
ABI	, 1 and Health em 27 ther tr			Chesney Lane - Bel		nryland 2° Oc. Location - City or	1014
SEPTEMBER Itimore. Ma	nt of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory`or other place)		•	
SEF	nit. Per artme ortant injury			el Luth.Cem. $09/30$			
Ba	permit. Depart Import any inj			1750 Belair Road -			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en				Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition PANCREATIC CANCER				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				
	Examiner		Sequentially list conditions, b.				
	B ₩.₩	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertifying Cause (Disease or injury that initiated events				
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_	tificat ng phy as the	ledi			- Vercellellar		
Box	death certife attending at for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of del	*
О.	ires that the death certificings by the attending of the detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
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WA	w require been si should b	etec					
EARL al Rec	The law sate has b	Completed			24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
EA tal	ician: The certificate ector, pag		25. Was case referred to medical	26 Place of Deat		No 1 ☐ Yes	2 🗆 No
<u> </u>	Physician: r this certific ral director,	o Be	examiner? 1	045		nce 6 X Other (Spe	cify) HOCDTCF
0	nding Physician: th. : After this certifica ? funeral director, p	n: T	27. Manner of Death 1 Natural 5 Pending		28d. Describe how		HOST ICE
Sio	tendil eath. or: A the fu	catic	2 Accident investigation	M 1 ☐Yes 2 ☐No			
EARL WAI Division of Vital Record	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	eet and Number or Ru State)	ıral Route Number,
	pital ours a eral C		29a. Certifier 1X Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place	and due to the ac-	use(s) and menney as	a stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, da	te and place, and due	to the cause(s)
_	To t To t	Σ	29b. Signature and title of dertifier	29c. License number	290	d. Date signed (Monti	h, Day, Year)
	1		werthe 1 miles	DS 2/4)	04/2	4108
	15		30. Name and address of person who completed cause of death (Itam 23a) (Type,			1 '	,
	Sta	te	DR. ERNESTINE WRIGHT 2300 DULANEY 31. Date filed (Month, Day, Year) 32 Registrar's Signature	ALLEY RD. TIMONI	UM, MD 21	1093	
	Registr		31. Date filed (Month, Day, Year) OCT 0 1 2008 33/ Registrar's Signature				

EARL WALTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, 2. Date of Death C Month **Physician** /Medical institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vursing +tome Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Min. 1 □ M 2 🕱 F 80 Months Days Hours **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Denison Stree 21229 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any Injury or other traumatic event, Ite Madical Examinat once. Armed Forces Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use jetired) 15. Decedent's Education (Specify only highest grade completed) Nood home College (1-4or 5+) 17 Father's Name (First, Middle, Last 18. Mother's Name (First, Middle Maiden Surname) Be awrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Noures 1 11818 mD 21502 avelle Girahami 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore 10.3.08 21. Signatur of Funeral Service Licensee CallBreene Funeral Services. Nat'l Pila (21229) (0 Deer 5151 Balto. Nati 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
FEW M. THS CARDIOMY . PATHY Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>8</u> EMB.LISM, PULM. NRARY 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy this certificate 2 **N**0 ⊺□Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number ٥ 10062634 SEPT 30,20.8 HICKORY RIDGE RD COLUMBIA MD 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWAN TEEN 1.802 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar OCT 0

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

Amend #1, per MD #19a, per FH g884 10/2/ 08 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death Ellie Wilson, Jr. 2. Date of Death **Physician** 10.10A /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Street Date of Birth Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. Days Months Hours Director Usual Residence of Dec Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show ir than "natural", or items 23a or 28a-f sho 1 des 2 □ No Director MD Hmore 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 27 is marked other er traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဥ 19a. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other troops. 20a. Method of Disposition Date 20c. Location 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from Signature of Funeral Service Licenses Koad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4thers claret (and ovasular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner O ichetas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Examiner Due to (or as a consequence of): After this certificate has been signed by the attending physician and funcial director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Records, P.O. 1 ☐ Yes 2 ☐ No. g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 ☐ Yes 2 1 No 1 ☐ Yes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manger of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LOUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 Rm 20 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland	/ Department of Health and Mental Hygiene	_

DHMH 17 Rev 1/2001 OCME 2006	_			THE REAL PROPERTY.	a ff	OF	IGINAL				•	n	OME	
State Registrar	31.	Date filed (Month)	Pay Year) 5 200	8 /32 Reg	istrar's Sign	nature	3							
3	ĺ	Donna M. Vino	centi, MD	ho completed cause Assistant Me			111 P	enn Street	M.E. H, Baltimo	re, MD 2	21201	September 1	3, 2008	
To the Howithin 24 P. To the Funcompletely	one	2 Me	edical Exam	sician: To the best iner: On the basis of and manner sta	examinatio	n and/or in	nvestigation	, in my opinio 29c. Licen	n, death occ se number	ce, and due	e time, date a	nd place, and due	to the cau	Day, Year)
S fill	29	Suicide 6 Homicide Certifier 1 Ce	determ	nined (Specify)				actory, office			or Town, Sta	ate)		oute Number, City
Division of Vital Records, spital or Attending Physician: The law requirmouts after death. neral Director: After this certificate has been sifilled in by the funeral director, page 2 should be Certification: To Be Completed	27 1 2	Manner of Death X Natural 5 Accident	Pendir Investi	ng gation	Day,Year)		Time of Inju	1	ury at Work? Yes 2	No		ow injury occurred		
f Vita Physici er this o	L	examiner? 1 Yes 2	No			-	utpatient 3	DOA	Other ₄	Nursing H		Residence 6	Other.	
ital Rectician: The certificate rector, page		Was case referred	to medical					26.Plac	e of Death (Check only	1 Y Yes 2		Yes	2 No
Records, The law require frate has been signage 2 should be Completed					-						24a. Was autops	y pri		y findings available letion of cause of
S, P.O. uires that the a signed by the detache	7					———	g in the unc	enying cause	givenin Pa	rt I.	1 Yes	2 No 3	_	4 Unknown
). Box 68' (the death certification by the attending tiched for use as the Physician).	Pa	Yes 2 No			wn	•	- Julio	(Specify)	wives in Da	-11	Logo Dident			
Box 6876 e death certificat the attending phy ed for use as the hysician/M		Was decedent pre past 12 months?	egnant in the	Live bil		2			Ectopic	pregnanc	у	23d Date of d Month	leliver y Day	Year
760, ficate be executed by physician and the burial - transity/Medical B	E	X UNPENDED		AMENDED -			E, g8	84 10/	30/08 	TT				
ecuted and transit		vents resulting in de		Due to (or as a d				_ , ,						
ted Insit Examiner	if Ca (C	any, leading to imm ause. Enter Underly Disease or injury tha	ediate ring Cause	Due to (or as a	consequen	ce of)								
	s	condition resulting		Due to (or as a										
/Medical Examiner	Immediate Cause (Final disease a. <u>Dilated cardiomegaly complicated by pneumonia</u>										pproximate Interval Between Onset and Death			
M មួន គឺធ្វើ Physician	2:	23g Part I Enter the disease of complications that we have									D 20736			
Baltimore, permit. Pages I ar Department of Hee Important: If ite	4	Donation 5	Other Sp	ecify:		Ceda	dar Hill Cemetery 2008					Suitland, MD		
ore, MC ges I and 2 st of Health an If item 27; ther trauma		Da Method of Dispo	sition	3 Removal fro	12	0b. Place? crema	of Dispositi story or othe	on (Name of or place)	cemetery,	Sep	Uppe: ^{Date} 26	r Marlbo 20c. Location -	City or Tov	D 20772 vn, State
MD 21 td 2 should tlth and Me n 27 is ma aumatic ev	2 1	9a. Informant's Nam William		nip (Type, Print) tte (husb	and)				eet and Nun	nber or Ru	ral Route Num	nber, City or Towr	, State, Zı	Code)
ID 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	ָן נְי	7. Father's Name (F Thomas		,	_					r's Name (F lores		Maiden Surname)	Jon	nes
within 7: iene ler than Medical	ompieted	12			-4 0r 5+)		Homen					Ow	n Hon	ne
"natura Examin		15. Decedent's Edu		or Dates: cify only highest grad		ed) 16a	. Decedent's	S Usual Occup st of working I	pation (Give	kind of wo	rk done d)	16b. Kind of Bus	siness/Indu	istry
9	y runeral	Never Married Widowed		Armed For 1 Yes orced If Yes, Give Year	2 X	No		s, specify Cub res 2 🗶 1			ican, etc.)	White Specify:		
with the ns 23a or be notified		1 Marital Status	d Crai	n Highway	edent Ever	20772 or in U.S. 13. Was Decedent of Hispanic Origin?				igin? (Spe	cify Yes or No		SA - American	Indian, Black,
ith the Maryland 23a or 28a-f show any notified at once.	Ulrector	0e. Street and Num	ber			pper	pper Marlboro 10f. Zip Code				11	0g. Citizen of Wh		
d now any	- 1	0a. State 1 MD	Ob. County	e George'		-	n or Locatio							Od. Inside City Limits Yes 2 X No
Director	⊢	212-94-47		1 M 2 X F	4	14 	Yrs.	Months D	ays Hour	s Min.	Dec 5	5, 1963 Foreign Country Wash. DC		
Funeral		Southern Ma	umber	6. Sex	7. Age (In						8. Date of Bir	Prince George's f Birth(MM/DD/YYYY) 9 Birthplace (State or		
	4	_	not institutio	n, give street and nu		_	4	c. City, Town,	or Location	of Death	Septembe	4c. County of		2330 1115
Physician Medical Examina	n/ 1	. Decedent's Name Michel			dette						2 Date of Dea	eg. No uth Day Yea er 12, 2008		Time of Death 2338 hrs
		For State				Certific	cate of	Death			g,.cc	oa No		

08-07133 David Wayne Beck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 31369

		1- For State Registrar	Cert	tificate of	Death		Reg	j. No.	0100
Physicia	ın/	Decedent's Name (First, Middle,La	ast)			=	2. Date of Death		3. Time of Death
ledical Exami	ner	David Way				10000	September	19, 2008	0444 hrs
		4a. Facility Name (if not institution, g Calvert Memorial Hospita			b. City, Town, or L Prince Frede			4c. County of Deat Calvert	h
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24Hrs	-	(MM/DD/YYYY) 9. Bi Forei	an
Director			X M 2 F 30	Yrs	Months Days	Hours Min.	05-22-	-1978 °	ountry) VA
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	on				10d. Inside City Limits
<u>*</u> .	Ļ	MD Calver	+		North	Reach			1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip Code	Deach	10	g. Citizen of What Co	untry?
n the Maryland 3a or 28a-f sho		8925 Frederick A	venue		2071	4		USA	
t be n	Funeral	11. Marital Status 1 Never Married 2 X Marrie	12. Was Decedent Ever in U.S Armed Forces?		s Decedent of Hisp es, specify Cuban,			14. Race - Ame White, etc.	rican Indian, Black,
er dear			1 Yes 2 No	_	Yes 2 X No			Specific LTL -	
urs aft tural'	g o	15. Decedent's Education (Specify	Lor Dates:	16a. Deceden	t's Usual Occupation	n (Give kind of v		Specify: Whi 16b. Kind of Business	
5 72 ho m "na cal Ex	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life. I		red)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	d m	12	- 9	Union	Electric			Construc	tion
15-(Be C	17. Father's Name (First, Middle, La: Charles Wayne			18	i.motners Name Linda	(First, Middle, M		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	TO B	Charles Wayne 19a. Informant's Name/Relationship	Carried State Control	19b. Mailing	Address (Street			per, City or Town, Stat	
MD id 2 sho llth and m 27 is aumati		Brandi S. Beck,	wife	8925	Frederic	k Avenu		Beach, MI	20714
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours at ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin		20a. Method of Disposition 1 Burial 2 X Cremation 3		Place of Dispos rematory or oth	ition (Name of cem- ner place)	etery,	Date	20c. Location - City of	r Town, State
Baltimore, bermit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Speci	Met					Alexandri	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other tringury or other traumatic event, the Med		21. Signature of Funeral Service Lice	ensee					eral Home,	
Physician	\dashv	23a. Part I. Enter the disease, or cor	nplications that caused the death.	Do not enter the	ne mode of dying, s	armony . uch as cardiac c	r respiratory arre	ings, MD 2	Approximate Interval
/Medical		failure. List only one cause on							Between Onset and
xaminer		or condition resulting in death)	Due to (or as a consequence of		Lase comp	IICUCCU	D) MCCI		
	اي	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of	١.					-
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated	c						
ansit	ΔĬ	events resulting in death) Last	Due to (or as a consequence of):					
760, icate be executed physician and the burial - transit	/Medical	X UNPENDED	AMENDED 23a,27	per me	g885 11-	19-08 v	t		
760, icate be physicate burn the burn	We	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn	•				23d. Date of delive	ry
Box 68 death certif the attending of for use as	sician	past 12 months?	1 Live birth 4 Pregnant at time of dea	-41-	tal death 3 _ her (Specify)	Ectopic pregna	ancy	Month	Day Year
Boy e death the att	Physi	1 Yes 2 No 9 Unknow	wn g Unknown		ner (opeony)				
P.O. Ess that the canada by the detached	by P	Part II. Other significant condition	s contributing to death but not re	esulting in the u	inderlying cause gi	ven in Part I.			o the cause of death?
S, P.C puires that an signed I led be deta							1 Yes		autopsy findings available
Records, The law require	Completed			_			autops	y prior to	completion of cause of
tal Rection: The contificate ector, page	5						1 ✓ Yes 2		
Vital Rec ysician: The his certificate director, page	a	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpationt		of Death (Check		Residence 6 Oth	or.
Division of Vital tal or Attending Physician rs after death. al Director: After this certicel in by the funeral director.	은	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of I	000//	at Work?		ow injury occurred	61.
ion (tending eath.	틶	1 X Natural 5 Pending			1 Ye	es 2 No			
Visi or Att frer de Direct	ij	2 Accident Investiga 3 Suicide 6 Could no	28e Place of Injury - At ho	me, farm, stree	et, factory, office bu	ilding, etc.	28f. Location (S or Town, St		Rural Route Number, City
Divis spital or At tours after d neral Direct filled in by	Certification:	4 Homicide determin	ned (Specify)				or rown, St		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Ontook only	ician: To the best of my knowledg er:On the basis of examination ar						
To To con	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (M	lonth, Day, Year)
		Dundi	MINIO 1		O.C.N	1.E.	1	September 19,	2008
		30. Name and address of person wh					ID 0400		
		Donna M. Vincenti, MD	Assistant Medical Exam		Penn Street,	Baltimore, N	21201 U		
St Regist	ate rar	31. Date filed (Month, Day, Year) 4	2008 32. Registrar's Signatur	y Ap					
	_			4.	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month Year Harold William Bowie September 13 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c County of Death CHARLE Examiner 4b. City, Town, or Location of Death MEDICAL CENTER -ATA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, **Funeral** 1 XM 2 □ F Months Days Hours Min. 213-42-6724 Director 67 Maryland Aug. 26, 1941 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventher any injury or other traumatic event, the Medical Eventher and be notified at Director Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Maple Street 20640 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1√ Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: Dowie Harold Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abron William Bowie MArv Thelma E. Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty T. Deer Sister 6 MAple St., Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 16,2008
Trinity Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Md. 20640 21. Signature of Funeral Service Licens 23a. Part1. Enter ne disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. On a condition resulting in death) M00668 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) o the 9 Unknown 9 Unknown σ. ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Physician: The certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 PHo 1 patient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1-Natural (Month, Day, Year) 2 Accident 1 ☐Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

6:52P

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

1 XYes 2 □ No

Registrar DHMH 17 Rev 1/2001

State

Krishan

31. Date filed (Month, Day, Year)

MATHUR

32. Registrar's Signature

3500 old Washington Rd. Ste 102 Walderf, Md 20002

			1- State of Maryland / Dep	partment of Health and Nertificate of Death		ne _{No.} 2008 31371				
	Physici		Decedent's Name (First, Middle, Last) Brown M. Bell		2. Date of Death Month	Day Year 3. Time of Death				
	/Medio Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		2. 12, 2008 7:11 PM 4c. County of Death Anne Arundel				
4	Funeral Director		5. Social Security Number 419–09–0276 6. Sex 1 □ M 2 7. Age (In yrs. last birthda) 7. Age (In yrs. last birthda)	Months Dave House Min (Month Day V						
2.5	D		Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georges 10c. City, Town or I			1919 Alabama 10d. Inside City Limits				
h the Ma rr 28a-f s r notified	Director	10e. Street and Number	Bowie 10f. Zip Code	10g.	1 ☑ Yes 2 ☐ No Citizen of What Country?					
	ath with \$ 23a o	ralD	12916 Brunswick Lane	20715		U.S.A.				
5-0036	a within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ZEMNo If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Dican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
VIZIS-C		Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king 16b	. Kind of Business/Industry Jewelry Store				
land 2	be filed stal Hyg dothe event,	Be	12 17. Father's Name (First, Middle, Last) George McElwee	Owner 18. Mother's Nam Minnie	e (First, Middle, Maid					
Maryl	12 shou h and M 7 Is mar traumat	To		ling Address (Street and Number or Rui Brunswick Lane I	ral Route Number, Cit					
altimore,	of H		20a. Method of Disposition 20b. Place of Disposition 1 St Burial 2 Commetter, 3 Demonstrate cemetery, or		Date 20c	. Location - City or Town, State ntsville, Alabama				
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee	ın M. Taylo	or Funeral Home Annapolis, MD 21401					
8.	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause or cach line. Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death				
)	/Medical Examiner		Due to (or as a consequence of):	ructive Pulmon	avu Dis	lease				
	outed Id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):		3					
8/00,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last Due to for as a consequence of): Du [Monary]	Edema						
O. Box o	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year				
ב, ב	uires that the signed by Id be detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc					
necords,	The law rec te has beer age 2 shou	Completed by	,		24a. Was an autopsy performed					
	clan: ertifica ector, p	BeC	25. Was case referred to medical examiner?	26. Place of Deat	1 Yes 2 Name 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No 1 □Yes 2 □ No				
5	Physi this or ral dire	2	1 Yes 2 No Hospital: Suppatient 2 □ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time			6 □Other (Specify)				
5	nding th. r; After e fune	tlon	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	njury occurred				
22	To the Hospital or Attending Physician: within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)				
	e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier (Check only one) 2	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				
	To th Vithin То th	Me	29b. Signature of title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)				
) .	9		les (")	120060225	Se	Ptember 13, 2008				
Ì	12/60		30. Name and address of person who completed cause of death (Item 23a) (Type STEVEY HAMLETTE, M. P.	2001 Medical Par	kway Anna	apolis, MD 21401				
	Star Registra	100	31. Date filed (Month, Day, Year) 32 Jegistrar's Signature	borle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 10 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2130 PM MARGUERITE R. BIVENS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 54115641 HICOMICO If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 03/08/38 Hours Months 1 M 2 X Davs Country **V**A **229-46-0175** 70 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at VΑ Temperanceville Director Accomack 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 31448 Temperanceville Rd. 23442 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 212Y5-0036 1 ☐ Yes 2 🔼 No Specify **Black** ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welcome Center Attendant is marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiry or other traumatic event ODEs. 17. Father's Name (First, Middle, Last) Be Silas Townsend **Dorothy Pitts Ross** ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23442 31448 Temperanceville Rd., Temperanceville, VA Clarence Bivens, Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Spec 09/21/08 Shiloh Cemetery Atlantic, VA 2. Sweature of Funera S 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc., Accomac, VA disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. 23a. Part 1. Enter the Approximate Interval Between shock, or heart failure nset and Death Immediate Cause (Final disease or condition resulting in death) (ancz **Physician** UZMOUS /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if a y, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ospital or Attending Physician; The law requires that the death certificate be executed burial-t Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has lirector, page 2 s autopsy performed? Yes 2.2.No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after dea h. neral Director. After this y filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 2 hours a To the uneral I comple ely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar PARROLL St. SAlisbury MR 2180

nd address of poson who completed cause of death (Item 23a) (Type, Print)

1A4/OR

2008

18

31. Date filed (Month, Day, Year)

SEPT. 17,2008

Funeral Director

an	1 State RegIstrar 1. Decedent's Name (First, Middle,		Cei	rtificate of l	Death	2. Date of Deat Month	h Day Ye	8 3 1 3 7 ar 3. Time of Death	
cal ner	ETTA M. CLOUG 4a. Facility Name (If not institution, CORSICA HILLS N	give street and number)		4b. City, Town, or	Location of Deat		4c. County of E	Death	
			94 (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreig Country) ARYLAND	
Director	10a. State 10b. County MD QUEEN	ANNE	10c. City, Town or Lo	ecation REVILLE				10d. Inside City Limi 1 🛣 Yes 2 🗀 N	
al Dire	10e. Street and Number 210 W. WATER	STREET		10f. Zip Code 21617			10g. Citizen of What Country? USA		
d by Funeral	11. Marital Status 1 ▼Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? ed 1 Yes 2 N If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 ☐ Yes 2 ▼ No Specify:			Black, V	American Indian, Vhite, etc. WHITE		
Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5-	(Give	ident's Usual Occupation • kind of work done during most of working DO NOT use retired) MINISTER			16b. Kind of Busine MINIST	•	
To Be Co	17. Father's Name (First, Middle, La EUGENE CLOUGH					me (First, Middle, M	faiden Surname)		
	19a. Informant's Name/Relationship MRS . MARGARET M. 20a. Method of Disposition		P.O. 20b. Place of Dispo	BOX 564,	GREENSB	ORO, MD 2			
	1 XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Signature of Furieral Signature of Furieral Signature Lie	ecify)	CHESTERF	TELD CEME 2. Name and Addres	TERY 9-1		CENTREVII		
	·Che M	1.46/	40	08 S. LIB	ERTY ST.	. CENTREY	ILLE, MD	The state of the s	
da 1	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. CONGEST	TIVE HEART a consequence of):		g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death YEARS	
_	Sequentially list conditions h. HYPERTENSION								
cal Examiner									
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year	
<u>a</u>	Part II. Other significant condition DEMENTIA	ns contributing to death bu	at not resulting in the u	nderlying cause give	en in Part I.		acco use contribu es 2 □ No 3 □	te to the cause of death?] Probably 4 █Unknov	
þ	24a. Was an 24b. We autopsy pric performed?								
Completed by								h? Yes 2□No	
Be Completed by	25. Was case referred to medical examiner? 1 Tyes 2 1 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatier	nt 3□ DOA Oth	or.	1⊡ Yes 2 ath (Check only one	2 No 1 🗆	Yes 2□No	
To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. Injur	er: 4 X Nursing I	1	2 No 1 🗆	Yes 2□No	
To Be Completed by	examiner? 1	28a. Date of Injur (Month, Day	y 28b. Time o Injury	f 28c. Injur World	er: 4 X Nursing I	1 Yes 2 ath (Check only one Home 5 Reside 28d. Describe ho	Proce 6 Other (a) winjury occurred	Yes 2□No	
Certification: To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no determin 29a. Certifier 1 CertifyIng	28a. Date of Injur (Month, Day ation of be 28e. Place of injur	y Year) 28b. Time o Injury ry - At home, farm, str. (Specify) of my knowledge, deat examination and/or in	f 28c. Injur Worl M 1 =	er: 4 X Nursing I / at Yes 2 □ No	ath (Check only one tome 5 Reside 28d. Describe ho 28f. Location (St. City or Town	No 1 □ nnce 6 □ Other (winjury occurred) reet and Number of State) ause(s) and manner	Yes 2 No Specify) If Rural Route Number, or as stated.	
To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident 6 Could no determin 29a. Certifier 1 CertifyIng (Check only 2 Medical E	28a. Date of Injur (Month, Day ation of be ned 28e. Place of injur building, etc.) 28e. Place of injur building, etc.	y Year) 28b. Time o Injury ry - At home, farm, str. (Specify) of my knowledge, deat examination and/or in	f 28c. Injur Worl M 1 =	er: 4X Nursing h √ at Yes 2 □ No ne, date and place pinion, death occ	ath (Check only one tome 5 Reside 28d. Describe house 128f. Location (St. City or Town e, and due to the courred at the time, d.	No 1 □ nnce 6 □ Other (winjury occurred) reet and Number of State) ause(s) and manner	Yes 2 No Specify) If Rural Route Number, or as stated, due to the cause(s)	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 12 Day **Physician** WESLEY 2008 P. COLLIE 9:05 PM Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Montgomery Olney If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1 🗷 M 2 🗆 F 243-50-3390 73 Director North Carolina June 21 1935 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County items 23a or 28a-f shor Director Md. Montgomery Brookeville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20833 3009 Gold Mine Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the "Actical Exant 1 Yes 2 If Yes, Give Year or Dates: 1955-1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ White 3 Widowed 4 Divorced 1958 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Accountant 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Mae Eddins Van Buren Collie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia R. Collie / Wife 3009 Gold Mine Road, Brookeville, Md. 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9/16/08 Alexandria, Va. Metropolitan Crem. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses marie Barlie P. O. Box 5038, Laytonsville, Md. 20882 -23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EPIDURAL HEMATOMA /Medical Due to (or as a consequence of): Examiner HEAD WITH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam sician and burial-tran COMPLETE Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at d be detached for 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2X No HYPERTENSION 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 □Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours a ler death.

To the Funeral Director After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 10 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 🗹 No 9 08 2008 12 NOON 2/X Accident FALL AT HOME 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide 3009 GOLD MINE BROCKEVILLE MD 1 Arertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0027322 09/16/zc08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. PRINCE REED SHNIDER 18109 PHILIP DR OLNEY MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 SEP 17 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September Day 13, 2008 3:45am Gertrude Elizabeth Countiss /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2380 Ironwood Drive Charles Waldorf 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 X F Months Hours Min 214-32-9942 Director 90 09/23/1917 Maryland Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location or 28e-f ehow 10d. Inside City Limits the Medical Example rivest be notified at 1 X Yes 2 □ No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2380 Ironwood Drive 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 neturel', or 1 Yes 2 No Specify: ģ 3 XWidowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental James N Campbell Frances Chesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20656 permit.' Pages 1 and 2 s Department of Health an Importent: If item 27 is any injury or other treu John E.Campbell/ Son 26155 Barnes Ct. Mechanics ville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Marys 9/20/08 Bryantown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A08 **Physician** Ъ C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 200 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death, 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eppleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who ce 0 0 1703 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:05 P M Coleson 15 2008 Roger David \$eptember 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Charles 4565 Friendship Acres Drive Nanjemoy If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ₹ M 2 □ F 88 Yrs February 9,1920 Wisconsin 473-44-5728 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 ☐ No Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4565 Friendship Acres Drive 20662 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No I ₩es, Give Year or Dates: 1942/1971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) United States Airforce 5 Pilot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emmett Coleson Florence Wendt Coleson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie Coleson/Wife 4565 Friendship Acres Drive Nanjemoy, Maryland 20662 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 11 Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. St. Mary's Ave. La Plata, Maryland 20646 M01458 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical **Examiner**

physician and s the burial-transit

Box 68760,

P.O.

Division or Vital Records,

or Attending Physician:

Hospital within 24 hours a completely

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show a notified at

items 23a or 2 iner must be no

ral", or item

Medical

th.

t. Pages 1 and 2 should be filed w trment of Health and Mental Hygie rtant: If Item 27 is marked other t ijury or other traumatic event, th

Department of Healt important: If Item 2 any injury or other

Director

Funeral

þ

Completed

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

one c	Pro tell Campel	631,
a	Due to (or as a consequence of):	
b	Due to (or as a consequence of):	
c	Due to (or as a consequence of):	
d	,	
23c.	If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □Ectopic pregnancy	23d. Date

Examiner Physician/Medical Completed by Be 2 Medical Certification:

1 Yes 2 No	4∐Pregnant at time of death 9⊡Unknown	5 ☐ Other (specify)
art li. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part I.

use contribute to the cause of death?										
] No	3 ☐ Probab	oly 4	Unknown						
	24b.	Were autops	y finding:	s available						

Day

Year

23d Date of delivery

Month

23e. Did tobacco

24a. Was an autopsy performe

1 ☐ Yes 2

25. Was case referred to medical examiner?

23b. Was decedent pregnant in the past 12 months?

				_
26. Place of Dea	th (CI	neck (only one)	
Other: 4 Nursing H	ome	30	Residence	6
Injury at	28d.	Des	ribe how in	jury

Krishan Mathur, M.

b.	Were auto prior to co death?	psy findings available mpletion of cause of	
		2 No	

	1 ∐ Yes	AL M
27.	Manner of	Death
	1 Afatura	al
	2 Accid	ent
	A	1

	Ho	ospital:
Pending nvestigation	1	28a. Date of Injury (Month, Day Yea

М	28c. Injury at Work? 1 ☐ Yes	2□No

☐Other (Specify)	
occurred	

3 ☐ Suicide 4 ☐ Homicide	9
-----------------------------	---

5 ☐ Pending investigation	(Month, Day Year)	In
6 ☐ Could not be determined	28e. Place of injury - At ho	ome, fari

ury	М	1 ☐ Yes	2 🗆
n, stree	t, facto	ry, office	

28f.	Location (Street and City or Town, State)	Number or	Rural Route	Number

6

29a.	Certifier
	(Check only
	one)

31. Date filed

P	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated.
_	

29b. Signature	and title of	certifier	
•	FX	(0)	
30. Name and	address of p	person w	who completed cause of death (Item 23a) (Type, Print

1	29c. License nu	ımber		
İ	0 2 0) >	~	1
	シタイ	- <		

Su. Da	7//	6	10	J.
D	_			

State Registrar

strar's Signature

O

2 ER/Outpatient 3 DOA

28b. Time of

			For State Registrar	State o	f Marylan		artment of h rtificate of		and M		giene Reg. No. 2	008	31377
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ıth		3. Time of Death
	Physici /Medio		Thelma Louise Cooper							Septem Septem	ber 1	5. 2008	8 01:45 P ^M
-	Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	r Location of				ounty of Death	
and!			Crofton Convalesce	nt & Rehabi	litation (Center	Crofton				Anr	ne Arun	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔏 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 11/15/	h <i>y, Y</i> ea <i>r)</i>	Con	hplace (State or Foreign untry)
	Director		579-09-0230 Usual Residence of Decedent	IL WI ZLAFI	94	Yrs.				11/15/	1913	Wasl	hington,D.C.
	and		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Maryl f sho	ō	Marvland Anne	Arunde1	Ног	wood							1 □Yes 2X No
	the l	rec	10e. Street and Number	Arunder	IIai	wood	10f. Zip Code				10g. Citize	n of What Co	untry?
	3a ol	Funeral Director	4750 L Flanders	Lane			20776				Unite	ed Stat	tes
	ms 2	ner	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Decedent of I	Hispanic Orig	gin? (Spe	cify Yes or No-		. Race - Amer	rican Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	þ	1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Fo ed 1 □Yes If Yes, Gi Year or D	2 🔁 No ve		if Yes, specify Cub 1 □ Yes 2 No	Specify:	, Puerto F	ilcan, etc.)		Black, White pe <i>cify:</i> W	nite
0-10	2 hou	Completed	15. Decedent			16a. Dece	dent's Usual Occup	oation			16b. Kind	of Business/I	Industry
21	thin 7	nple	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	d) most	or workin	9			
	filed within Hygiene. other than "	Co	12			Home	maker				Ног		
nd	tal H d oth	Be	17. Father's Name (First, Middle, I	,				18. Mother	r's Name	(First, Middle,	Maiden Su	ırname)	
Maryland	ould banker	မ	UNKNOWN Goodin							UNKNOW			
Jar	2 sh h and ris m		19a. Informant's Name/Relationsh				ng Address (Street						
	l and lealth sm 27		Michael C. Coop	er/Grands			L Flande			arwood,			
lor	Pages 1 ment of H ant: If ite ury or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from	State 20b. F	cemetery, crei	sition (Name of natory or other pla	ce)	Da	ite	20c. Loca	tion - City or I	rown, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once.		4 □ Donation 5 □ Other (S)		Geoi	rge Wash	ington Cem	etery 09	9/19	/2008	Adelp	hi, Ma	ryland
Bal	permit. Departr Importa any inju		21. Signatur	icensee		22	2. Name and Addre	ess of Facility	f Facility George P. Kalas Funeral Home ns Island Road, Edgewater, MD 21037				
			23a. Part 1. Enter the disease, or	complications that	rausod the deat							ewater.	
		S 2	shock, or heart failure. List	only one cause on e	each line.	n. Do not en	er the mode of dyr	ng, such as t	cardiac of	respiratory at	1631,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a fire	froctor	alla	- Chi	ease					
-	Examiner			Due to	r as a conseq	uence of):							
		je l	Sequentially list conditions,	b. Due to	or as a consol	lience of):							
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
o,	e exe ian ar ırial-tı		resulting in death) Last	Due to	(or as a conseq	uence of):							
8760,	cate be executed physician and the burial-transit	dical		d									
		Med	IF FEMALE:										
Вох	eath certifi attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna birth 2□Feta	Ideath 3	Ectopic pregnanc	су			23	d. Date of deli Month	ivery Dav Year
0	Physician: The law requires that the death certifutes this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unkr	nant at time of one	death 5 L	Other (specify) _					Worth	Duy
σ.	that the deneed by the detached		Part II. Other significant conditio	ns contributing to d	eath but not res	ultina in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
Records,	uires tha signed d be det	d by	Dementia	3		3	,·g g			1 DY	es 2 🗽	No 3□Pr	obably 4 ☐ Unknown
COL	w requir been s should	Completed	- Julian Vice							24a, Was			tone, findings evollable
Re	ne law e has ge 2 s	du								autop perfo	sv	prior to death?	topsy findings available completion of cause of
Vital	hysician. The k his certificate ha I director, page 2		25. Was case referred to medical							1 □ Yes	2 No	1 □ Yes	2 No
>	s cert) Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	EB/Outpation	ot all pool Oth	or		(Check only o		Tother (C	-16.1
		n: To	27. Manner of Death	28a. Date	of Injury	28b. Time of				ie 5 ☐ Resid 8d. Describe h			city)
ion	Attending It death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investig		th, Day, Year)	Injury		k?]Yes 2 □ N	10				
Division	Atte	tific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200, Place	of Injury - At ho	ome, farm, str	eet, factory, office		2	Bf. Location (S City or Ton	Street and I	Number or Ru	ıral Route Number,
Õ	talog rs afte al Dir	Certification:		Buildi	ing, etc. (epecin				V	Only of You	n, olate)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo		(Check only 2 Medical I	g Physician: To the examiner: On the b	asis of examina	wledge, deat ition and/or in	h occurred at the ti	ime, date and opinion, deat	d place, a	nd due to the d at the time,	cause(s) a date and p	nd manner as lace, and due	s stated. to the cause(s)
	thin 2 the 1 the 1	Medical	one) 29b. Signature and title of certifier	and man	ner stated.		29c. Licens	e number			20d Data	signed (Month	h Day Year)
	¥ ¥ 6		1 Vi	W.A.	LIA A		7) 7 (2000	2		9/	I C I	1 P
	1,040)	30. Name and address of party	who completed as	V//)	0 22a\ /T:=-	U 5 5	7>0			1/	0/0	0
	114		30. Name and address of person v	viio completed caus	ac death liten	(Type,	208 /	27/100	M	1	01.	1.0.	Bymie 210
	Sta	te	31. Date file (Month, Day, Year)		egistrar's Signa	ture	100 L	iun	1119	nully	0 00	VTIM	. Pullacalo
	Registra		SEP 16	2008	hour ,	& A	rection		V	V			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician Ethelene Louise Dorsev** /Medical September 14. 2008 9:40 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 □ M 2 □XF Director 63^{Yrs} 213-44-3954 January 16, 1945 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov Director MD Prince Georges Capitol Heights 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death v 160 Daimler Drive 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 🗷 No 3 XWidowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Retail marked other event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental James Dorsey Carrie Johnson and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 is
any injury or other trau Frank S. Taylor - Brother 6156 Stephen Reid Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Emestine Jones Cemetery** 9/19/2008 Chesapeake Beach, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gladys a. Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ventralow disease or condition resulting in death) mmulse /Medical Due to (or as a consequence of): Examiner minules -cule Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed Deffuse and Due to (or as a on equence of): burial physician s the burial Box 68760. Physician/Medical as IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Day Year 5 ☐ Other (specify) P.O. ed by the a 1 ☐ Yes 2 No 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page autopsy performed? Division of Vital 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After 28b. Time of To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI D24720 9-14-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYNDER K. Res TAGI. 6132 ANDOVER CHEVERLY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP

16

2008

32. Registras Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 1:40P. M Davidson 2008 Henry Parker September 18. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F 81 579-36-7033 Sept.14,1927 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Examinar must be notified at 1 ☐Yes 257 No Director Maryland St. Mary's Charlotte Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 29449 Charlotte Hall Rd. 20622 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 11∆Yes 2 No If Yes, Give 45–1947 Year or Bates. 5–1947 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n. College (1-4or 5+) Elementary/Secondary (0-12) Retail Tile Company Salesman 4 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Parker ပ္ Heath Dulany 1 and 1 Davidson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra 4425 Romlon St., Apt.#2, Beltsville, MD 20705 Beth Bergere/Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition otember 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3 2008 Charlotte Hall, MD Brinsfield-Echols 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A 21. Signature of Fufferal Service bio 30195 Three Notch Rd., Charlotte Hall, MD 2062223a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** RRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-tran Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HYPERTENSION 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? PULMONARY DISEASE 24a. Was an autopsy performed: 1 ☐Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at 4 Work? ne Hospital or Attending Pin 24 hours after death.

The Funeral Director; After the pletely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. To the I within 2.

State Registrar

te filed (Month, Day, Year)

EENA

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAO

29c. License number

29d. Date signed (Month, Day, Year)

-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 19, Mary Martha DeFalco 2008 9:09 AM September 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 30,1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕱 F 217-16-8666 89 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Maryland St. Mary's 1 ☐ Yes 2 🛣 No Dameron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18624 Tall Pines Road 20628 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 21 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaner Dry Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory Evans Mary Geneva Forrest 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles DeFalco / Son 18624 Tall Pines Road Dameron, MD 20628 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State September 20, Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1 Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSIVE /ARDIOVASCULAR disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed DISCASE 1 ☐ Yes 2 ☐ No 1 □ Yes 2, Z No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it worked to the real Evanine must be presented.

Baltimore, Maryland 21215-0036

/Medical

Director

by Funeral

Completed

Be ဂ္

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit

Exami Physician/Medical Completed by Be ٩ Certification:

Division of Vital Records, P.O. Box 68760,

Part II. Other significant co	onditions contributing to de	ath but not resulting in the underly
CHRONIC	KIDNEY	DISEASE

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

ATTENDING PHYSIUM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

determined

MOMOH MD

2 ☐ Accident

4 ☐ Homicide

31. Date filed /Month

3 ☐ Suicide

29a. Certifier

Medical

8706 CENTRAL AV H301, LAND OVER MD 20785

28f. Location (Street and Number or Rural Route Number, City or Town, State)

09-19-2008

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 24, **Physician** John 2008 Dickson 5:50 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care & Rehabilitation Center Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Aug. 24, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 √M 2 ☐ F 068-24-9157 93 1915 Scotland. Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experience mast be notified at Maryland Frederick 1 No 2 No Director Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2509 Coach House Way, Unit 2A 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: if item 27 is marked other than "natural", or ite 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 🗙 Specify: þ Specify: White XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Textile Designer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Hope Dickson Margaret Scott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 Is
any injury or other trau
once. Mrs. Pamela D. Siedor, Daughter 935 Eastland Road, Waynesboro, PA 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Sept. 29, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility
Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD 21701 MOO255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ement /Medical Due to (or as a consequence of): Examiner avdiomyo Sequentially list conditions, if any nating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Medical

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

death with the Maryland

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 25, 2008 MD 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick temen 31. Date filed (Month, Day, Year) 2. Registrar's Signature

State Registrar



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sept. **Physician** 22^{Day} 2008 Year 12:03 PM Shelley Lynn Decker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** May 6, 1971 1 □ M 2 🕅 F Months Maryland 214-04-1134 37 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2X No MDBALTIMORE FREELAND 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or with 1501 Freeland Road 21053 U.S.A. Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 □Yes 2X No Specify þ Specify: White 3 ☐ Widowed 4 🎇 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than " r traumatic event, the Me Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Customer Service Fleet Leasing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental Charles Edward Copenhaver Nancy Lee Sipe ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Charles E. Copenhaver/Father 1501 Freeland Rd., Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sept. 26, Middletown Cemetery 4 Donation 5 Dother (Specify) Freeland, MD 2008 21. Sunature of Furferal Service Licens 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 tar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER, MDNTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be execute the burial-trai Due to (or as a consequence of): Box 68760. ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Yea 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No P.0. 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ DIABETES 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed certificate 1 □Yes 2 No of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HDSPLLE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 X Natural after death. To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29b. Signature and title of co 29d. Date signed (Month, Day, Year)

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State Registrar

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September

DANIEUE DOBERMAN, MO 6565 N CHARLES ST, SUITE 209 BALTIMITE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Registrar's Signature

D64395

SEPTEMBER 22, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 31383 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death 2<u>1,</u> Joseph Clarence Evans, Jr. 10:30 P_M 2008 September 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Hours 1 ☑ M 2 □ F 214-42-3755 64 Maryland February 26, 1944 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland St. Mary's Morganza 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28735 Point Lookout Road 20660 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Harry Lundenberg Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Clarence Evans, Sr. Sarah Elizabeth Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Rose Young / Companion P.O. Box 124 Morganza, MD 20660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State September 29, Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 2008 21. Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final novee disease or condition resulting in death) Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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d other than "natural", or items 23a or 28a-f show event, the Medical Examiner is ust by notified at

with the Maryland

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Department of Health at
Important: If item 27 is
any injury or other trau
once.

1 and 2 should be Health and Mental

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law requires that the death certificate be exect Hospital or Attending Physician: 24 hours a

Physician/Medical

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Certification: To

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Part II. Other significant conditions	contributing to death but not resulting in the underlying cause give	en in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 Probably 4 □ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other	er: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investigation		y at 28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my knowledge, death occurred at the tin niner: On the basis of examination and/or investigation, in my of and manner stated.	me, date and place, and due to the cause(s) and manner as stated. pinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

State Registrar

DHMH 17 Rev 1/2001

within 2

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29b. Signature and title of certifie

7-charl 31. Date filed (Month, Day,



30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

Year)

524

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Blaine Sepkmber 16:44 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 □ F Yrs Director 181-48-8904 50 July 26, 1958 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must ha matified. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 😿 Yes 2 🗆 No Abbottstown PA Adams 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 354 Sutton Rd Funeral 17301 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip W. Fengfish Virginia E. Frey ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Becky K. Fengfish wife 354 Sutton Rd Abbottstown, PA 17301 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory S 22. Name and Address of Facility Sept 22. 2008 Smithsburg, MD 21783 21. Signature of Funeral Service Licensee #CCOYSG Feiser Funeral Home, Inc 302 L.W.W. New Oxford. PA 17350 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis

Due to (or as a consequence of): **Physician** 10 days disease or condition resulting in death) /Medical Examiner end stage disecse liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) 2 minth Physician: The law requires that the death certificate be executed burial-transit disersa Due to (or as a consequence of) rend resulting in death) Last Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) page 2 should be detached 9 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tyes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA ٥ 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1XNatural or Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident completely filled in by the Director: 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, 4 - Homicide determined City or Town, State) within 24 hours To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

State Registrar Zoe

31. Date filed (Month,

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. Registrar's Signature

MPH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2008

29c. License number

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29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

September 20, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** THELMA **GALFORD** 09 08 2250 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth Jan 3, 1933 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) 1 □ M 2 🖵 F Months Days Hours Min. Director 217-28-2454 75 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f shovevent, the Wedical Evanities are redified at MD Allegany Cumberland Director 1√2 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 36 E. Roberts Street Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify ≥ Specify: white 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Beauty and Hair Care owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Williams Maude Fadley Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 **Arthur Nester** 722 Washington Street Cumberland son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 9/26/2008 MDFlintstone 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, owneart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cluse (Final **Physician** Hypotension months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hear years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit Exami Pulmonary
Due to (or as a consequence of): and attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Hospital or Attending Physician: The this certificate Division of Vital 2 No 1 ☐ Yes 2 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aft

mpletely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

500 Memorial Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2008

IKINS MD 32. Registrar's Signature

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31. Date filed (Month, Day, Year)

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Arthelia B. Hurley 2008 September 14, 6:53 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dunkirk Calvert 10100 Kirksville Lane Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 □ XF 82 Director MOV. 14. MD <u>578-34-6016</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28s-6-6-2-10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits s 23a or 28a-f show Director 1 ☐ Yes 2 No MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10100 Kirksville Lane 20754 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. r than "natural", or items Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🗷 No Specify: \$ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be d 2 should be fith and Mental I Lydia Watkins other traumatic ဥ Otha Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 Is any Injury or other trans Norman Hurley - Husband 10100 Kirksville Lane, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cooper's UM Church Cemetery 9/18/2008 Dunkirk, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sladys a. Lowell Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De and Death Immediate Cause (Final disease or condition NDRO ME SINUS **Physician** ICK ler disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trai Due to (or as a consequence of) the attending physician thed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DEMEN LZHEIMER 3 Probably 4 Unknown 1 □ Yes 2 🗓 🎉 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🔽 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c Hospital: SITH 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

executed P.O. Box 68760, the death certificate be The law requires that Division of Vital Records, Hospital or Attending Physician: To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

Maryland 21215-0036

Baltimore,

State Registrar

Arlan 30. Name and address of person who completed cause of death (flem 23a) Type, Print)

MD DICLEY

29d. Date signed (Month, Day, Year) 008

PRINCE FREDERICK

and manner stated.

STOSP R.D. M.D. ANWAR MUNSHI. 110

31. Date filed (Month, Day, Year) SEP 1 5 2008

29b. Signature and title of certifier

32. Registra Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** George William Hawkins, Sr. 10:15 P M September 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Harwood 843 Harwood Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1. M 2 □ F 65 Director 216-40-9549 MD October 18, 1942 Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the "section Exerciting at Director 1 ☐Yes 2 No MD Anne Arundel Harwood 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with Funeral USA 843 Harwood Road 20776 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 ☒No Specify. ≥ Specify 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other trainmain any injury or other trainmain. Religion Pastor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Hawkins Helen Mackall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George W. Hawkins, Jr. - Son 8708 Bismark Dr. Ft. Washington, MD 20744 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church of God Cem. 9/20/2008 Lothian, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gladys a Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ned by the Ö 9 Unknow σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u></u> sign be 1 ☐ Yes 2 No. 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The page certificate perform 1 □ Yes 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 2 7 No 1 🗌 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1. Natural

2 □ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after death • Funeral Director: completely filled in by the 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29b. Signature and title of certifie, 29c. License number 29d. Date signed (Month, Day, Year) ype, Print) 30 Name am ted cause of death (Item) tew 6 31. Date filed (Month. Day. Year) 32. Regist State 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS G885 11/25/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mon 09 **Physician** 1404 2008 Ilalee Hodge 1:30PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bradford Oaks Nursing & Rehab Clinton If Under 1 Year If Under 24 Hrs. Hours Min. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗙 F Months Director 577-46-8892 74 <u>Sept. 7, 1934 Tennessee</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes XX No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8808 Dement Court USA 20603 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married _{Specify:}White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dock E. Duckett Pinola Presnell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet A. Bonsall/Daughter 8808 Dement Ct. Waldorf, Maryland 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Mem. Gardens Sept. 17,2008 Waldorf, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Huntt Funeral Home M01262 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 7He mais Immediate Cause (Final disease or condition resulting in death) D7 Sure **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t rector, page 2 s 1∐ Yes director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainler as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 30. Name and address of person Civing Im Ront 31. Date istrar's Signature

State

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 12,2008 2:25 PM JOHN WILEY HUNT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) DEC 7,1921 9. Birthplace (State or Foreign 1 M 2 □ F Months I MARYLAND 86 215 14 4998 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ☐ Yes 2 ☐ No ANNE ARUNDEL ANNAPOLIS MARYLAND 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code UNITED STATES 2613 POINT LOOKOUT COVE 21401 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No If Wes, Give WWII Year or Dates: 1 ☐ Yes 2 🗓 No Specify. Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) SALES REPRESENTATIVE CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM JOHN HUNT LULA PEACH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2613 POINT LOOKOUT COVE

ANNAPOLIS, MD. 21401

09-14-2008 | EDGEWATER,MD.

20c. Location - City or Town, State

29d. Date signed (Menth, Day, Year)

2

EDGEWATER, MD. 21037

Date

2973 SOLOMONS ISLAND ROAD

22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME

permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural" ~ " any injury or other traumatic event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or other event at a many injury or o **Physician** /Medical

Physician

/Medical

Examiner

10a. State

Funeral

Director

3a or 28a-f show t be notified at

Director

Funeral

þ

Completed

Be

AUGUSTA

21. Signature

20a. Method of Disposition

HUNT

4 □ Donation 5 □ Other (Specify)

29b, Signature and title of certifier

30 Name and addless of person

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Examiner The law requires that the death certificate be executed

attending physician and for use as the burial-tra signed b has e 2 page certificate

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

hours after Hospital

Examiner Physician/Medical ģ Completed Be ၉ Director: After this in by the funeral dir Certification: hin 24 hours after the Funeral Dire Medical

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause 171, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) npumon Due o (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of highly Due to (or as a consequence of): Cause (Disease or hijulithat initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗌 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

20b. Place of Disposition (Name of cemetery, crematory or other place)

KALAS CREMATORY

9

State Registrar

Day, Year) 31. Date filed (Month SEP 1 6 2008

40

(WIFE)

∌egistrar's Signature

no completed cause of death (Item 28a) (Type, Print)

	State of Maryland / Department of Health and Mental Hygiene 1- State Amended items 20b/c,9.17.08,SLU, WCHD Certificate of Death Reg, No. 2018 31396
Physician	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
/Medical	Jonathan R. Hastings, Sr. Sept. 14,2008 2352
Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) Solis bury Rehab alvurs moctor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 In Under 14 Hz. Months Days Hours Min. June 30, 1918 4c. County of Death Unicomico 9. Birthplace (State or Foreign Country) Country) June 30, 1918 Delaware
land bw it	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Mary a-f she ified a	DE Sussex Bridgeville
fire death with the Mar ritems 23a or 28a-f st inner must be notified Tuneral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
eral	18432 Hastings Mi11 Road 1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
J36	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Specify Cuban, Mexican, Puèrto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: Specify: White
21215-00 ed within 72 hou ygiene. Per than "nature t, the Medical E	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auctioneering
212 rd withi giene. er than the M	College (1-4or 5+) Auctioneer / Agri. Farmer Agricultural Farming
be filed that Hyging dother event, the Be Cc	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Maryland d 2 should be file th and Mental Hy 77 is marked oth traumatic event	William F. Hastings Eleanor (Gilbert) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Route Number. City or Town, State, Zip Code)
e, Mail 1 and 2 sh Health and Health and Sther traur	Jonathan R. Hastings, Jr./Son 18875 Atlanta Rd., Bridgeville, DE 19933
Baltimore, permit. Pages 1 a Department of Hee Important: If item any Injury or othe	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Lewes, DE
Baltimore permit. Pages 1 Department of F. Important: If ite any Injury or ot	4 Donation 5 Other (Specify) Bridgeville Cemetery 09/18/2008 Bridgeville, DE 21. Signature of Funeral Service License
Bal permi Depar Impor any Ir	21. Signature of Funeral Service License 22. Name and Address of Facility Parsell Funeral Enterprises, Inc. 202 Laws Street, Bridgeville, DE 19933
	23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Physician	Immediate Cause (Final disease or condition
/Medical Examiner	resulting in death) Due to or as a cons, quence of):
1- 10 mm	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Eithe Underlying Cause (Disease or injury that imitiated events c.
O, exect an and rial-tra	resulting in death) Last Due to (or as a consequence of):
icate be executed physician and the burial-transit dical Examir	d
Box 6 ath certific trending por use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
ds, P.O. I uires that the de signed by the a d be detached f d by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
or Vital Records, Physician: The law requires truthis certificate has been signe ral director, page 2 should be completed by	1 Yes 2 Ho 3 Probably 4 Unknown
al Record The law requirete has been so page 2 should	24a. Was an autopsy findings available autopsy prior to completion of cause of
The The page	performed? death? 1 Yes 2 No 1 Yes 2 No
Vita	25. Was case referred to medical examiner? 1 Types 25 No Hospital: 1 I position: 20 SP/Outpetient: 30 DOA Other: 4 Types 25 No Other:
Physic ruthis cral direction : To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Hoursing Home 5 Residence 6 LiOther (Specify)
ion nding th. : Afte e fune	27. Manner of Death 1 Landatural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 38c. Injury at Work? 2 Accident investigation 28c. Injury at Work? 1 Yes 2 No
Division or Vital Reconstitute to the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Compl	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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o the Hosp Ithin 24 houn o the Fune ompletely fil	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) And manner as stated. (Check only one) And manner as stated. (Check only one) And manner as stated. (Check only one) And manner as stated. (Check only one)
o the vithin 2 the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
FSFO	► / // // // / / / / / / / / / / / / /
884	30. Name and address of person who completed eause of death (Item 23a) (Type, Print)
0	William A- Robins, M.D. 200 Civic Ave. Salisbury, MDa 1800
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature
DHMH 17 Rev 1/2001	SEP 1 7 2008 Brown & Species
	ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar	Cer	rtificate of Dea	th	Re	g. No.	0 0100
Physician ledical Examine	Barbara		Hawthorne	200	2. Date of Death Month September	Day Year 21, 2008	3. Time of Death 0458 hrs
	4a. Facility Name (if not instituti Baltimore Washingto			Town, or Location of Burnie	f Death	4c. County of Death Anne Arundel	-1
Funeral Director	5. Social Security Number 303–46–5694	6. Sex 7. Age (In yrs. la	Mon	der 1 Year If Under ths Days Hours	24Hrs. 8. Date of Birtl Min. 04/26	(MM/DD/YYYY) 9. Bir Foreig /1953 Co	
daryland 28a-f show any 1 at once.	Usual Residence of Decedent 10a. State 10b. County MD Anne		Town or Location				10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f sho		Court	10f. Z	ip Code 21114	10	g. Citizen of What Coul USA	ntry?
fter death wi	3 Widowed 4 Di	Vorced If Yes, Give Year or Dates:	If Yes, spe	cify Cuban, Mexican, 2 No specify:		White, etc. Wh	can Indian, Black,
y, MD 21215-0036 and 2 should be filled within 72 hours a cath and Mental Hygiene. transmitter vern, the Medical Examination of the Committee of the Table of the	Elementary/Secondary (0-12	college (1-4 or 5+) College (1-4 or 5+)		al Occupation (Give k orking life. DO NOT a eeper		H&R Block	
ID 21215-003 should be filed within and Mental Hygiene. The marked other the marked other the marked other the marked other the Med	william	ə, Last)	Angel1	18.Mother's Jane	s Name (First, Middle, M	,	ugh
MD 21 d 2 should, the and Mer in 27 is man	William Lee Ha	awthorne Spouse	1562 Bar	ndury Cour	ber or Rural Route Num t Crofton,	MD 21114	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If iten 27 injury or other traum	4 Donation 5 Other S	on 3 Removal from State At	Place of Disposition (No crematory or other place lantic Crematory or other place)	e) natory	Date 09/23/08	20c. Location - City or Glen Burni	
	21. Signature of Eureral Service	J/(Harde		1 Home P.A.		
Physician /Medical xaminer	failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	or complications that caused the death e on each line. ALcohol at e a Zol idem, Cyc. Due to (or as a consequence of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the complete content of the co	nd mixed di lobenzapri	rug intoxi	cation (Buj	propion,	Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence o		- 1	<u> </u>		
ted nisit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	of):				
execular and all - tra		d	28a-f,perM	E,g884 107	7/08 TT		
	= 1230. Was decedent brednam in	4 Pregnant at time of de	2 Fetal deal		pregnancy	23d. Date of deliver Month	y Day Year
ires that the de signed by the	3	itions contributing to death but not re	esulting in the underlyi	ng cause given in Par		bacco use contribute to	
cords law requi					24a. Was a autops perfor 1 V Yes 2	sy prior to o med? death?	utopsy findings available completion of cause of es 2 No
/ital Recystrian: The nis certificate director, page	examiner?		ER/Outpatient 3	26.Place of Death (Residence 6 Othe	r.
of Viting Physic After this To I	Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	···
Division tal or Attendi rs after death. led in by the fu	Natural 5 Per 2 Accident Inve	estigation Fnd 9/21/08 28e. Place of Injury - At he		Yes 2 X		treet and Number or Ru	ural Route Number, City
Division o spiral or Attending nours after death. Ineral Director: After filled in by the func	3 Suicide 6 X Cou	old not be ermined (Specify) House		.,,	Crofton	, MD Band	ral Route Number, City lury Ct.
o Twit	Check only one) 2 Medical Ex	Physician: To the best of my knowledgaminer:On the basis of examination a and manner stated.	and/or investigation, in	my opinion, death occ		and place, and due to th	ne cause(s)
	29b. Signature and title of certification	er		9c. License number O.C.M.E.		29d. Date signed (Mo September 21, 2	
	30. Name and address of perso Pamela E. Southall, I	n who completed cause of death (Item MD Assistant Medical Exa		n Street, Baltim	ore, MD 21201		
Stat Registra		6 2008 32. Figistrar's Signatu	ore best				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death
September 14 2008 3. Time of Death **Physician** 12:39A M Doris Pittman /Medical James 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death THARLES MEDICAL ENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2√2 F 133 28 2752 Director Jan. 25, 1934 West Indies Usual Residence of Decedent 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director MD Prince George's Brandywine 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14066 Brandywine Road 20613 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∏Yes 2 ∏No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Thomas Halstead Injury or other traumatic ပ္ Caroline Crooke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau Jennifer Holmes/daughter 14066 Brandywine Rd Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other to Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Gardens 9-26-08 | Waldorf, MD 21. Signature of Funeral Service Licensee MIDAM 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old WashingtonRd Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician aurel disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ⊒HVo 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, after death Director: 24 hours a within 2

death with the Maryland

72 hours after

State Registrar (Check only

31. Date filed (Month S

29b. Signature and title of certifier.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6600

jistrar's Signature

Baig MD

Ste 102

Crain Hway

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 0 8

		•	For State Of Wall yland	Certificate o	f Death	Reg.			
	Physicia	an	1. Decedent's Name (First, Middle, Last) HARRY B. KELLAM			2. Date of Death Month 09/14/	Day Year 3. Time of Death 12:00 P M		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town	, or Location of Death	07/14/	4c. County of Death		
,			Anne Arundel Medical Center		polis	0. D / D'. #	Anne Arundel		
	Funeral Director		5. Social Security Number 6. Sex 1 → 46 6. Sex 1 → 46	Yrs. Months Day	ar If Under 24 Hrs. vs Hours Min.	8. Date of Birth (Month, Day, Ye 03/11/6	9. Birthplace (State or Foreign Country) VA		
	ryland how Lat			Fown or Location			10d. Inside City Limits 1 □ XX es 2 □ No		
	he Ma 28a-f s otifiec	ecto	<u> </u>	Wie 10f. Zip Code		100	. Citizen of What Country?		
	th with t 23a or 2 sst be n	al Dir	13117 Crutchfield Ave.	207		109	USA		
036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dicher than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Speuban, Mexican, Puerto No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black		
215-0036	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occ (Give kind of work dor	cupation ne during most of worki ired)	ng 16	b. Kind of Business/Industry		
7	within ene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Logistic		1	Government Contract		
N .	Hygi Ther it, t	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name				
ylar	ould b Menta rarked	To I	Issac Mapp			ine Kella			
Maryland	d 2 sh th and th and traum		19a. Informant's Name/Relationship (Type. Print) Dorlee Kellam, Spouse	19b. Mailing Address (Street 13117 Crutch			City or Town, State, Zip Code) MD 20720		
ē,	s 1 an of Heal item 2 other		20a. Method of Disposition 20b. Plac	ce of Disposition (Name of netery, crematory or other p			c. Location - City or Town, State		
Baitimore,	Page ment c ant: If jury or		1 Abunal 2 Ucremation 3 Unemoval from State	hel Cemetery	09/23	/08 F	ranktown, VA		
Rail	permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once.		mature of Funeral StrayGe Lio See	22. Name and Add		neral Co.	, Inc., Accomac, VA		
ě			23d Part1. Enter the disease, or complications the caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of o	dying, such as cardiac o	or respiratory arrest	t, Approximate Interval Between		
	Physician	0.7	Immediate Cause (Final disease or condition a. Stranger of the condition a.	troke			Onse and Death		
4	/Medical Examiner		Due to (or as a consequen	nce of):					
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):					
	ecuter and -transi	Examiner	Cause (Disease or hijury that initiated events c	nce of):					
68/60,	tificate be executed g physician and as the burial-transit	cal E	d.						
200		Medical	IF FEMALE:						
P.O. Box	The law requires that the death cert to has been signed by the attending age 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	eath 3 Ectopic pregna			23d. Date of delivery Month Day Year		
	w requires that is been signed by should be detailed	by	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause	given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the cause of death? 2 No 3 □ Probably 4 □Unknown		
Vital Records,		Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No		
VIta	sician: certific rector,	Be	25. Was case referred to medical examiner?	20.000	Other:	(Check only one)			
Division or	ng Phy fter this ineral d	tion: To	To tes 2010 To Inpatient 2 Er	28b. Time of lnjury 28c. In	4 □ Nursing Ho	me 5 ∐ Residen 28d. Describe how	ce 6 □Other (Specify) injury occurred		
DIVISI	ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A pletely filled in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	e, farm, street, factory, offi	ice	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)		
	a Hospit 24 hour 5 Funer: etely filk	ical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle and manner stated.	on and/or investigation, in n	ny opinion, death occur	red at the time, dat	te and place, and due to the cause(s)		
	To the Hos within 24 ho To the Fur completely	Me	29b. Signature and title of Sertifier	29c. Lic	ense number > 46052	290	d. Date signed (Month, Day Year)		
7	3+1		30. Name and address of person who completed cause of death (Item 2	3a) (Type, Pint) Lice Parhway	annapo	es, MD			
	Sta	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pint) State 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature SEP 1 8 2008							

			1 – For State Registrar	State of Marylar	-	artment of F rtificate of I			eg. No.	18	310	394
	Physici		1. Decedent's Name (First, Middle, Las	η Christina Ross	si Kueh	n		2. Date of Deat Month	Day	Year	3. Time of 3:25	Death A M
1	/Medio		4a. Facility Name (If not institution, give		or Ruen		r Location of Death	Бергешь	er 20,		J.2J	
	LXaiiiii	101	Chesapeake Shore		ter		ton Park			Mary'	S	
	Funeral		5. Social Security Number 6. S	7. Age (In yrs	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Countr	ice (State o	or Foreign
	Director		220–78–9476 1 Usual Residence of Decedent	LM 2LAF 82	Yrs.	,		September	24,1925	Bras		
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				100	d. Inside Ci	ity Limits
	Mary a-f sh	żó	Maryland St. I	Mary's		Califor	rnia				1 □ Yes	2 √ No
	h the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wi	nat Countr	y?	
	death with the Maryland ims 23a or 28a-f show r initial by in titled at	ra	23190 Woodland A	cres Road		206	19		В:	razil		
	tems	nue	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- Americar	n Indian, c.	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐Yes 21X No If Yes, Give Year or Dates:		1 □Yes 2 🛣 No	Specify:		Specify:	Wh	ite	
21215-0036	2 houra	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	- 1	16b. Kind of Bus	iness/Indu	stry	
215	thin 7. e. an "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work i)				_	
21	ed wil	Completed by Funeral Director	12	4	Li	brarian			niversi		brary	<i>'</i>
Maryland	be fill ed oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	,	_	_		
Ž	hould ad Me mark matic	ပ္	Antonio Ros 19a. Informant's Name/Relationship (7)		10h Mailir	na Addross (Street	Math: and Number or Run			eres	Cada)	
	od 2 sulth ar 27 is r trau		Annette Gisoldi /		23190	Woodland	d Acres Ro	d. Calif	ornia, l	MD 20	619	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Exports at most be notified at once.		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place	(00		20c. Location - C	City or Tow	n, State	
m	Pages ment of I ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		norial Garde	Septe	mber 27,	Leonardto	wn, Ma	ryland	
alt	permit. Page Department of Important: If any Injury or once.		21. Signatu Funenal Service Licen			2. Name and Addre	ss of Facility		D 4			
Ш	20599	K1 9	Muchael	Janaine	_	P.O. Box 2	-Gardiner F 70 Leonard	town, MD 2	20650			
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only	olications that caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Ir C	Approximate Interval Bet Onset and I	e ween Death
and a	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cadio AL	Ima	nay a	nu					
Separate Sep	Examiner			Due to (or as a chised	quence of):	JI50	1.4.0	d25000	2-			
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):	-11100	conf					
	ecutec nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Coronas	1-	2256	020					
30,	oe execian a	Ë	resulting in death) Last	Due to (or as a co sec	quence of):							
68760,	tificate be executed g physician and as the burial-transit	ledical		d					.11			
9 x	certific ding p		IF FEMALE:	23c. If yes, outcome of pregn	ancv				00-l D-t-			
Вох	death cert	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta 4 Pregnant at time of	al death 3[☐Ectopic pregnanc ☐Other (specify)	у		Mon	of delivery oth D		Year
P.O.	that the de ned by the a detached t	Physician/N	9 Unknown	9 Unknown								
S, F	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	by P	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tok	acco use contril	bute to the	cause of d	death?
ord	w requires t s been signe should be o							1 □ Ye	s 2 No (3 Probat	bly 4 🗖 l	Unknown
Records,	e law r has be e 2 sh	Completed						24a. Was ar autops	y pr	lere autops	sy findings	available ause of
		ပ္ပ					_	perforn	ned? 📗 de	eath? □Yes 2	! □No	
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat					
of	<u>a</u> + <u>e</u>	1: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	IT 3 L DOA	4 Nursing Ho	me 5 Reside				
Division	nding Phy th. :: After thi e funeral c	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Worl	(?	200. 20001120110	m mjary occarro	u		
Visi	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (St	reet and Numbe	r or Rural i	Route Num	nber,
	talor rs afte al Dir led in	Certification: To	1					City or Town	,			
	Hospi 4 hou Funer tely fill		(Check only 2 Medical Exam	sician: To the best of my kniner: On the basis of examin	owledge, deatl ation and/or in	h occurred at the till vestigation, in my c	me, date and place, pinion, death occur	and due to the c	ause(s) and mar ate and place, a	nner as sta	ited. the cause(s	s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens						<u> </u>
	F≥≓8	-	252. Organization and this of certifier	and mo		N 201	12 Mas	wland "	9d. Date signed	1), rour	
			30. Name and address of person who d	ompleted cause of death (Itel	m 23a) (Tvpe	Print)	10	0,-1	11-1	-10	J	
	5		Youngsik MOON	MD P.D.	Box-	37 H	OLLUGIM	a ma	20636	,		
	Sta	te	31. Date filed (Month, Day, Year)	32. egistrar's Signa	ature	- A 0	7	1				

DHMH 17 Rev 1/2001

State

Registrar

SEP 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER ^{Day} 23 2008 2:55 P ARNOLD LEITH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Days 216-60-4879 1 X M 2 □ F 55 Director September 15, 1953 Maryland Usual Residence of Decedent 10a, State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director Frederick Jefferson Maryland 1 ☐ Yes 2 1X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 4832 Pioneer Circle 21755 items 23a Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 X Married Maryland 21215-0036 0 1 □Yes 2🎦 No If Yes, Give Year or Dates: Specify White à Specify: 3 ☐ Widowed 4 ☐ Divorced natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Department of Transportation Elementary/Secondary (0-12) College (1-4or 5+) Road Worker marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Samuel Leith Ruby Lyrid ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Health a 109 South Bentz Street, Apartment 6, Frederick, Maryland 21701 Brenda Leith / Wife Department of Health Important: If Item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ment of F September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 27, 2008 21. Signature of Funeral Service Lie 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Intracrania) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HTN Sequentially list conditions, if any landing to the cause. Enter Underlying Cause, Oisease or injury that initiated events Physician/Medical Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗖 No 1 ∐Yes 2 1 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊡∕No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 □Yes 2 □ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only

within 24 hours after deat To the Funeral Director:

UDURAMPOLA 400 West Seventh Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) egistrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

29c. License number

067750

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day Winifred Roop Moran Sept. 18, 2008 10:16 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 44824 Joy Chapel Road Hollywood 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/15/1927 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 E F Months 80 212-24-6268 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director 1 ☐ Yes 2 No MD St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or death with 44824 Joy Chapel Road 20636 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: d other than "natural", or items event, the Medical Evaminer me 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evanture once. 1 Never Married 2 Married 1 ☐Yes 2 ☒No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethe1 Engler Ralph Geiman Roop Grace ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ralph Moran (son) 24417 McIntosh Road, Hollywood, Maryland 20636 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Cem. 9/19/2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle Simons MO1 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAN (ER OLON Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2√2No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has birector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Baltimore, Maryland 21215-0036

Other: 4 \(\text{\subset}\) Nursing Home 5 \(\text{Hesidence}\) Hesidence 6 \(\text{\subset}\) Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

D56096

24035, THRE NIGHED HULLIWOOD

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 2 2 2008

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CILL 32. Registrar's Signature

MID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 22, 2008 **Physician** 1:05 A M John Roger Murphy /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 38980 Foley Mattingly Rd. Mechanicsville If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M M 2 □ F Days 218-54-6564 63 Director September 22,1945 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Evaminer must be notified at 28a-f show Directo 1 ☐ Yes 🛣 ☐ No Maryland |St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38980 Foley Mattingly Rd. 20659 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1968 1∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 K No þ Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sand and Gravel Company f Health and Mental Hygier item 27 is marked other the other the other than matic event, the Heavy Machinery Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Sylvester Murphy Lillian Alvey ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Murphy/Wife 38980 Foley Mattingly Rd., Mechanicsville, MD 20659 ce of Disposition (Name of Date 20c. Location - City or Town, State item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's 9/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensite 30195 Three Notch Rd., Charlotte Hall, MD 20622 0081 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADENOCARCINEMA 9 MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it is a line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending nse 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for (3 Ectopic pregnancy in the past 12 months? Year Day ed by the a ☐Yes 2☐No 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signated bage 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 Xivo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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To the I within 2.

State Registrar

29b. Signature and title of certifier

30. Name and address of person



completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

MKCHAMCS VILLE, Md 20659

			For	State of Maryland /				Mental Hygi	ene 2 0 0 8	3 3 3 8
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	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
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ore	to to		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Re	emoval from State	e of Dispo etery, crer	sition (Name of matory or other plac	e)	Date 2	Oc. Location - City of	or Town, State
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1	B IX		30. Name and address of person who co	mpleted cause of death (Item 23)	a) (Type,	Arlo#18	/bon	x Mixi	baren K	10 20112
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature		P at	- 11 4			
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Baltimore,	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Even that is ust be ruffled at once.		21. Signature of Juneral Service Live	-	Gate of	22	Name and Addres					er Sprii eral Hoi		
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	the death. Do n	ot ente	er the mode of dyin	g, such as ca	ardiac or	respiratory a	rest,		Approximate Interval Bet	e ween
	sician		Immediate Cause (Final disease or condition	a HTN.	M Seizi	ire	Disorder						Onset and I	Death
	ledical aminer		resulting in death)		consequence o		T. ALD. A. M. S.							
		<u>.</u>	Sequentially list conditions,		al Palsy									
uted	Insit	ij	Cause, Enter Underlying Cause (Disease or injury	Die to to a se	action constant	ų.								
эхес	ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence o	f):								
od rou, ficate be executed	attending physician and for use as the burial-transit	dical		_d										
	ing ph		IF FEMALE:								- 1			
Physician: The law requires that the death certif	or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal death	3 □	Ectopic pregnancy	,			2	3d. Date of deliv	•	(
. e	the shed	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗆	Other (specify)					Month	Day Y	/ear
that t	signed by the a		Part II. Other significant conditions	contributing to death but	not resulting in	the un	derlying cause give	n in Part I.		23e. Did to	bacco us	se contribute to t	he cause of d	eath?
uires i	n sign Id be	d by								1 □ Y	es 2[]No 3∏ Pro	bably 43£1	Jnknown
aw requir	s peen s	Completed								24a. Was a	n .	24b. Were auto	nev findings	availahle
The la	age 2	E O								autop perfor	sy med?	prior to co death?	mpletion of ca	ause of
an:	ii o	0	25. Was case referred to medical					26. Place of	f Death (_ 1 □ Yes Check only o	2¥⊆No ne≀	1 □ Yes	2 ∐No	
hysic	his ce I direc	To B	examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatien	t 2 ER/Out	patient	3 □ DOA Othe	r.				☐Other (Speci	fy)	
- g	offer t		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day,		ime of jury	28c. Injury Work	at	286	d. Describe h	ow injury	occurred		
Attending	the f	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	9				′es 2∐No						
lor A	Direct I in by	Certification:	4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At nome, fari (Specify)	m, stre	et, factory, office		281	Location (S City or Tow	treet and n, State)	d Number or Run	al Route Numi	ber,
Hospital	y filled	- 1	29a. Certifier 12 Certifying Ph	yslcian: To the best of	my knowledge,	death	occurred at the tim	ne, date and	place, an	d due to the	cause(s)	and manner as	stated.	
the Ho	To the Funeral Director: A completely filled in by the fi	edical	(Check only 2 Medical Exar	niner: On the basis of and manner state	examination and	l/or inv	estigation, in my op	oinion, death	occurred	at the time,	date and	place, and due t	o the cause(s))
To th	To t	ž	29b. Signature and title of certifier				29c. License	number		:	29d. Date	signed (Month,	Day, Year)	
			h	seem			D006	4578			Sep	tember 2	23, 200	8
			30. Name and address of person who											
	Stat	0	Mehmooda Naeem 31. Date filed (Month, Day, Year)	M.D.	1522. 's Signature	5 S	hady Grov	e Rd.	, Roc	kvill.	e, M	D 20850		
	Stat Registra		SEP 25	2008	s signature	A								
			*				00-C-771-F5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem I per doc 8884 10-2-08 vt amend #178194e Pt Marward 885e part 19708 Hallth and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Clayton George Nielsen Year **Physician** Month 9:00 A M September 13, 2008 Clayton George Niels /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert County 645 Tide Head Way Lusby If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1**X** M 2□ F 578-22-4420 April 15, 1925 Wisconsin Director 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director MD Calvert County Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r 645 Tide Head Way 20657 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced "natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Federal Government Civil Engineer other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental I pe Revere Nielson Revere Nielsen Gladys Gallun 19a. Informant's Name/Relationship (Type. Print) **Liese Nielsen** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Liese Nielson 645 Tide Head Way, Lusby, Maryland 20657 (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If Ite any Injury or of once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 13, Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) <u>Anatomy Gift Registry</u> 2008 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fune 8125 Southern Maryland Blvd., Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG Physician RHEUMATOID 1/2 months /Medical Due to (or as a consequence of): Examiner many years RHEUMATOD ARTHRITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 88 IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HTN CAD PAD CUPD. 1 PYes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? page death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 4No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩6 1 Inpatient 2 ER/Outpatient 3 DOA ဥ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 36969 9115108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11910 H.G. Trueman Road, Lusby, Maryland 20657 Scaria Mathew, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 1 6 2008

forts

State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 25,2008 Physician Month Beatrice Rosella Oliver September 1:27 A.M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagers town 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🕅 F Yrs. Director 219-14-5164 84 Feb. 24, 1924 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Examinar must be notified at 10d. Inside City Limits Director Md. Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 373 Key Circle 21740 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 □Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygient Important: If Item 27 Is marked other the any injury or other traumatic event, ITel 9008. Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Rice Helan H. Jewell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Dodson (Daughter) 242 Pangborn Blvd. Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept Date 27 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Smithsburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 081 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physician and resulting in death) Last Due to (or as a consequence Division of Vital Records, P.O. Box 68760 Physician/Medical enn as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal deat 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ndemra icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? this certificate 1 ∐Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🗶 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

he Funeral Director; A
pletely filled in by the fu 2 Accident 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26/08 D0066116

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State Registrar 51

REET

Hagerstown MD 21740.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

ALI, KNDALGEB
31. Date filed (Month, Day, Year)

368 MILL

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day September 14,2008 1:53p^M Elizabeth E Proctor 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Clinton Nursing and Rehab Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/25/1922 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🔀 F Months Days Yrs. Maryland 86 577-32-1407 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Clinton Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20735 7707 Old Alexandria Ferry Road 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Application Examiner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Newman Elizabeth Proctor James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20735 19a. Informant's Name/Relationship (Type. Print) 7707 Old Alexandria Ferry Rd.Clinton, Maryland William Harley Jr./nephew 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/23/08 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Resurrection 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Pineral Service License 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final TOCA disease or condition resulting in death) Due to (or as a consequence of): 44.1 on Tr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗹 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 1∐ Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

and

attending physician

certificate

After

ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t

within 2

certificate be executed

Box 68760.

P.0.

Records.

Division or Vital

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examlner must be notified at

the Medical

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12 should be filed w h and Mental Hygie 7 is marked other tl

Pages 1 and 2 should nent of Health and Men

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

Be

Examine burial-trar Physician/Medical the as nse 2 Completed Be 2 Certification:

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

State

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date/signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Branch Ave Sute 409 Clinton, Maryland 20735 7801 old MASSEOW

31. Date filed (Month, Day, Year) 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 2008 9:06AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OMICO Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 10 M 2□F 62-8815 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic svent, the Madical Examiner must be notified at 1⊌ Yes 2 No Funeral Director Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1980 1 ☐ Yes 2 ☐ No by Specify 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Kepnirs 12 Installer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If is any injury or injury or * 4 ☐ Donation 5 ☐ Other (Specify) Dover Rect remoti 21. Signa 22. Name and Address of Facility eral Service L 917. 3186 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of): resulting in death) /Medical Examiner crhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): resulting in death) Last Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 🗌 Yes 2 10 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 2 No 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 🗆 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63 30. Name and address of oere completed cause of death (Item 23a) (Type, Print) Princess 2137 1500 Street MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 17 **200**8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 31404 State of Maryland / Department of Health and Mental Hygiene 🕕 🖯 💍 For

		1 - State Registrar			Cei	rtificate	e of L	Death			Reg. N	lo.			
		Decedent's Name (First, Middle, La	ist)					-		2. Date of D	eath		Vaar	3. Time of De	eath
ysici: Andic		DIANE	D .		REID)				Month SEPT		12	2008	1840	М
Medic amin		4a. Facility Name (If not institution, give	ve street and num	iber)		4b. City,	Town, or	Location o	f Death		4	c. Count	of Death		
		9331 PEERLESS RO		7 Ane (In vrs	. last birthday)	If Under		IOPVI		8. Date of B	irth		RCEST		Foreian
eral ctor		214-52-1063 Usual Residence of Decedent	1□ M 2\(\frac{1}{2}\)F		58 Yrs.	Months	Days	Hours	Min.	AUG. 24	ay, Yea 4, 1	950	MAF	place (State or F ntry) RYLAND	
福		10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	10d. Inside City I	Limits
Illiad	ctor	MARYLAND WORCE	ESTER		BISHO	PVILI	E				,			1 🗌 Yes 2	X No
1 be no	i Director	10e. Street and Number 9331 PEERLESS F	CAD			10f. Zip	Code 2181	3			10g. C	itizen of US	What Coul	ntry?	
2	Funerai	11. Marital Status	12. Was Dece	dent Ever in I	U.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	cify Yes or N	10-	14. Ra	ce - Americ	can Indian,	
the Medical Exercites the notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 ☐ Yes If Yes, Give Year or Da	9	1	If Yes, spec		Specify:	, Puerto I	Ricen, etc.)		Specii	ck, White, 5: WF	etc. HITE	
loa	ted	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usua kind of wor	al Occupa	ition	t of workir	na	16b.	Kind of B	lusiness/In	dustry	
ITIS MAG	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	SECRE	se retired)		or workin	·y	D	ISTR	IBUTI	ON	
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	To E	CHARLES	DING	ES					OROTE		_	MCCA			
other traumatic		19a. Informant's Name/Relationship	_							I Route Numi		or Town 137		o Code)	
other tra		MICHAEL C. COLLI	INS/SON	20b.	Place of Dispo			ا وبلله		FIELD,	_			own, State	
ō		1 X Burial 2 ☐ Cremation 3 [State	cemetery, crer	matory or o	ther place	9)	9/16				•	, MARYL	AND
injury e		* 4 □ Donation 5 □ Other (Special Service Lice	-	100000000000000000000000000000000000000	-	2. Name an		s of Facilit		700	DI	31101	, TDDD	, rimitio	
any i		1 Wille W	H was						-	Æ, SEI	LBYV	ILLE	, DEI	AWARE 1	.997
		23a. art Enter the disease, or conshock, or heart failure. List only	pplications that ca	used the dec	th. Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory	arrest,			Approximate Interval Betwe	en
ian		Immediate Cause (Final disease or condition	One cause pine	ion into.		ASC	00							Onset and Dea	ath
ical		resulting in death)	a. Due to (d	or as a conse	quence of):	1(00	,								
iner		Sequentially list conditions,	b												
sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):										
ıl-tran	хап	that initiated events resulting in death) Last	c. Due to (c	or as a conse	quence of):								-		
the burial-transit													- 4		
as the	/Medical		Q												
detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Fei ant at time of	tal death 3	Ectopic pr Other (sp							ate of delive	ery Day Yea	ar
be detac		Part II. Other significent conditions	contributing to de	ath but not re	sulting in the u	nderivina c	ause give	n in Part I		23e. Did	tobacce	use con	tribute to t	he cause of dea	ith?
5	d by	•				, ,				1 🗆	Yes	2 🗆 No	3 Prol	bably 4 Dunk	known
	Completed									24a. Wa	s an	24b.	Were auto	opsy findings av	ailable
page 2	d d									aut	opsy formed?		prior to co death?	mpletion of cau:	se of
	ပိ	25. Was case referred to medical						26 Place	of Death	1 Yes		No	1 🔲 Yes	2 No	
director	0 B	examiner? 1 ☑ Yes 2 □ No	Hospital: 1 🗆 Ir	patient 2[☐ ER/Outpatier	nt 3 DC	Othe			ne 5 Res		6 □ Qtl	her (Specia	fy)	
funeral	Ë	27. Manner of Death		f Injury h, Day Year)	28b. Time of		8c. Injury Work			28d. Describe					
on et	atio	1 Natural 5 Pending 2 Accident investigation	on	i, bay roai,	injury	М		/es 2 🗆	No						
lin by th	Certification;	3 Suicide 6 Could not be determined	286. Place	of Injury - At ig, etc. (Spec	home, farm, str hify)	reet, factory	, office	1.2	2	28f. Location City or To			ber or Run	al Route Numbe	er,
stely filled	ledicai C	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Ex	hysicien: To the miner: On the ba and mann	sis of examin	nowledge, deat nation and/or in	h occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, a	and due to the	e cause e, date a	(s) and m	anner as s	stated. o the cause(s)	
etely			-			<u> </u>					001.5		1 () () -16	Day Year)	
completely	Me	29b. Signature and title of dertifier				290	. License	number	•		29d. L	ate signe	d (Month,		
completely filled in by the	Me	29b. Signature and title objectifier				290	License	number	8	mo	290. L	ate signe	08 of J		

31. Date filed (Month, Day, Year)

SEP 1 7 2008



State

Registrar

Certificate of Death

2. Date of Death

3. Time of Death

Birthplace (State or Foreign Country)

West Virginia

10d. Inside City Limits

1 ☐ Yes 2 No

months

110000

September 15, 2008 10:05 PM

USA

Specify:

14. Race - American Indian,

white

Crosson

Black, White, etc.

Smith

1. Decedent's Name (First, Middle, Last)

Jean

Dorn

Physician

/Medical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician;

ate has been sign page 2 should be

ģ

Be Completed

Certification: To

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. A Due to (or as a consequence of):	novascular Dis	ense	years,
resulting in death) Last	Due to (or as a consequence of): d.			
IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
Refractory Anemia	contributing to death but not resulting in the underland Bleed	, ,	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
	re Syndrome k n and Cerebrovascular	typertension Diseaso	24a. Was an autopsy performed? 1∐ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2 ER/Outpatient 3	26. Place of De	ath (Check only one)	6 ∏Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigati		28c. Injury at Work?	28d. Describe how inju	iry occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier (Check only one) 1 Certifying I	Physician: To the best of my knowledge, death occ aminer: On the basis of examination and/or investi and manner stated.	curred at the time, date and plac gation, in my opinion, death occ	e, and due to the cause(s urred at the time, date ar	s) and manner as stated. Id place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)
Gendel P. S	Sterner M.D.	D 17243	Sep.	tember 16, 2008
	completed cause of death (Item 23a) (Type, Print			20-04
Gerald P. Stern	er, M.D., 19 Ches. Beac	h Road East, O	wings, MD 2	20736
31. Date filed (Month, Day, Year) SEP 1 8 2008	32. Registrar's Signature			
	OPICI	NIAI		

State Registrar

To the

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Ronald Thomas Sewell September 13, 2008 0850 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Hospital of Cecil County **Elkton** Cecil 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1**X** M 2□ F Months Days Hours Min 217-82-1724 Sept. 22,1975 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "hedical Experience must be neither in 1 ☐Yes 2 X No Director Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item. any injury or other traumatic. 56 Maple Hill Drive 21904 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ð White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) R.T. Sewell Trucking Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Port Deposit, Maryland Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Linda S. Pennington Grafton A. Sewell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Maple Hill Drive, Port Deposit, Maryland 21904 Linda S. Sewell (Mother) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09/19/08 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery Port Deposit, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 0 Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 8 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transi Exami and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal deat The law requires that the death 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2☐No Ö 9 Unknown 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 X No been 8 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes 2 No **Director:** After this certific d in by the funeral director, 25. Was case referre to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | X | 10 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes death. 2 🗌 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by after 4 ☐ Homicide e Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Rajal Shah, M.D., 106 Bow Street, Elkton, Maryland 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	1 - For State Registrer	State of M	Maryland / Dep Co	oartment e <i>rtificate</i>				giene2 (800	3140
Physician	1. Decedent's Name (First, Middle Robert Em		h Gr				2. Date of De Month	Day	Year	3. Time of Death
/Medical				4h City T	own or Lo	cation of Deat		ber 24	ty of Death	12:50P.M
Examiner	13400 Smithsbur		,		ith s b		11		shing	rt on
Funeral	5. Social Security Number		Age (In yrs. last birthda	y) If Under	Year If	Under 24 Hrs	8. Date of Bir	th	9. Birthp	lace (State or Foreign
Director	214-32-2741	1 % M 2□F	80 Yrs.	Months	Days	Hours Min.	July 9	y, Year) ,1928	Mary	itry)
p .	Usual Residence of Decedent 10a. State 10b. County		100 City Town or	Landina						Od Inside City Limite
aryla shor			10c. City, Town or						'	0d. Inside City Limits 1 ☐ Yes 2 No
he N	Md. Wa.	shington	Smit	hsburg	2-1-			10- 03	(14%	
be filed within 72 hours after death with the Maryland lat Hygiene. tal Hygiene. d other than "naturel", or Items 28e or 28e-1 show event, the Medical Exandriar rount be notified at the Medical Exandriar rount be notified. Be Completed by Funeral Director	13400 Smithsb	ura Pike		10f. Zip (217 8 .	7		10g. Citizen o	7.S.A	itry ?
eath	11. Marital Status	12. Was Decede	at Ever in U.S. 13	Was Decede			necify Yes or No		ace - Americ	an Indian
ter d	1 Never Married 2 Marr	Armed Force	s?	If Yes, speci	fy Cuban, I	Mexican, Puer	pecify Yes or No to Rican, etc.)	BI	ack, White,	
el', o	3 Widowed 4 □ Divorced	If Yes, Give Year or Date:	50-52	1 ☐ Yes 2	No S	Specify:		Spec	ify: W.	hite
ed within 72 houygiene. Set than "nature It, the Medical E	15. Decedent		16a. Dec	edent's Usual	Occupatio	n		16b. Kind of	Business/Inc	dustry
Pan "n Medi	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	life	O NOT use	done duri retired)	ng most of wo	rking			
d with	9	ouiiogo (· · · ·		Mainte	nance			GOV	ernme.	nt
be filed tal Hygie d other event, the		Last)			18	. Mother's Nar	n <i>e (First, Middl</i> e,	Maiden Suma	ime)	
		mith				Rutl	I. Rid	enour		
	19a. Informant's Name/Relations	nip (Type, Print)	19b. Ma	iling Address	Street and	Number or Ru	ural Route Numbe	er, City or Tow	n, State, Zip	Code)
1 and 2 Health tem 27 i	Kathy A. Boswe	ll (Daughte					Smithsb			
les 1 al of Hea of rothe	20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Sta	20b. Place of Dis	position (Name ematory or other	e of ner p(ace)	Sept	Date 29,	20c. Location	•	
Pag ment ent: I ury o	`4 □Donation 5 □ Other (S)		cemetery, cr Cedar La Par	wn M e mo k	orial		008	Hagers	town,	Md.
permit. Pages i Department of H importent: If ite any injury or of once.	21. Signature of Funeral Service	icensee		22. Name and			1: L Home Si	2525 Br	adbur	y Ave.
cate be executed the burial-transit the burial-tran		b. — Sue to (or a	as a consequence of):					J)
eath certification attending process as for use as			2 Fetal death 3	□Ectopic pre					ate of delive	ery Day Year
that the ded by the detached	9 □ Unknown	9□ Unknown								
igne bed by	Partii. Other significent conditio	ns contributing to death	but not resulting in the	underlying ca	use given in	n Part I.	1	obacco use co res 2 🗆 No		ne cause of death? abiy 4 □Unknown
ate has b							24a. Was autop perfo	an 24b esy rmed? 2.200	. Were auto prior to cor death? 1 Yes	psy findings available npletion of cause of 2 No
Physicien: The this certificate ral director, page To Be Col	25. Was case referred to medical				26	. Place of Dea	ath (Check only o	ne)		
% <u>s</u> : S		Hospital: 1 🗆 Inpa	tient 2 ☐ ER/Outpati	ent 3 DOA	Other:	4 ☐ Nursing ⊦	lome Kesid	tence 6 □O	ther (Specify	/)
Attending Proceedings of the death. Sector: After the py the funeral file attent.			jury 28b. Time Day Year) Injury	of 28	c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe h	now injury occu	ırred	
r sign	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place of I	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory,	office		28f. Location (S City or Tox	Street and Nun vn, State)	ber or Rura	l Route Number,
the Hospitel of this 24 hours a thin 24 hours a the Funerel E mpletely filled i mpletely filled i Medical Ce		Physician: To the best examiner: On the basis and manner	of examination and/or i	ath occurred a investigation, i	t the time, on my opinion	date and place on, death occu	, and due to the oursed at the time,	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)
within 2 To the complet	29b. Signature and trie of certifier			29c.	License nu	ımber		29d. Date sign	ed (Month,	Day, Year)
> = 0	X//W	<u></u>				590			5.0	8
	30. Name and address of person v		death (Item 23a) (Type 2911 Jeff	Print)	BU	vn Si	n mussi	my i	NO 2	1783
State Registrar	31. Date filed (Month, Day, Year)	2008 32. egis	trar's Signature	Lucks				A		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month John E. Simmons September 25, 2008 8:15 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Solomons Nursing Center Solomons Calvert 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day. 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Director 214-28-4924 90 Maryland 04/28/1918 Usual Residence of Decedent 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Maryland Calvert Port Republic Director 1 ☐Yes 2 ☐XNo 10f. Zip Code 20676 10e. Street and Number 10g. Citizen of What Country? 2940 St. Leonard Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mechanic civil service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elbert C. Simmons Anna Rausch ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel E. Simmons -son 2145 Brian's Way Lusby, MD 20657 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Oct 3 2008 1 Burial 2 □ Cremation 3 □ Removal from State Port Republic Maryland 4 Donation 5 Dother (Specify) Christ Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. SHOWER 4405 Broomes Isl. Rd., Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of); Par Ki~se~ 5 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → 6 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred

The law requires that the death certificate be executed physician and s the burial-trans Box 68760 attending nse for ed by the a detached f P.O. signed I Division or Vital Records, been certificate has page 2 Physician: funeral director, this After t Hospital or Attending death. after death the within 24 hours after dea

To the Funeral Directo

within 72 hours after

1 and 2 should be filed withir Health and Mental Hygiene. em 27 is marked other than

Maryland 21215-0036

Baltimore,

Certification: To

1 Natural ∠ □ Accident 3 ☐ Suicide 4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

00255

28f. Location (Street and Number or Rural Route Number, City or Town, State)

September 25, 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. John Barth, III, MD 14090 Solomons Isl. Rd., Suite 2500, Solomons, MD 20688

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 0 1 2008 32. Registrar's Signature

the

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 10:18 PM Mary H. Weiland 17 September 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Leonardtown 22680 Cedar Lane Court 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 X X F Director 91 08/15/1917 Maryland 215-36-4036 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a State 10h Counts 10c. City. Town or Location 28a-f show 7 Is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Exeminer must be notified at 1¶∑Yes 2 □ No Director Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22680 Cedar Lane Court Apt. 1223 20650 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. ģ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Servant U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Benjamin Franklin Aud Mary Irene Miles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra Joseph H. Weiland/Son P.O. Box 1244, Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery crematory or other place)
Immaculate Heart 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/22/2008 Lexington Park, MD Mary Cemetery 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons MO1206 22955 Hollywood Road Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. such a pardiac or respiratory arrest, Immediate Cause (Final **Physician** EVMUN MO disease or condition resulting in death) /Medical Due to (a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or ultim is doubly not Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as 1 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♣ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 ☐ Yes 2 ② No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20636 James P. Jarboe, M.D. 24035 Three Notch Road, Hollywood, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 2 2008 Book B April ORIGINAL State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician 3) AM a te 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner chah Date of Birth (Month, Day, Year) (In yrs. last birthday Yrs. 6 Sex **Funeral** Months Days Min 1□M 2XF Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Street and Number 10f. Zip Code 10g. Citizen of What Country? CC Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 212 No 1 🗌 Yes Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Indust (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 04 Ke 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KNOWN ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CCT 20a. Method of Disposition 20b. Place of Disposition cemetery, crematory Date 20c. Location - City or Burial 2 ☐ Cremation 3 ☐Removal from State SNOW 4 ☐ Donation 5 ☐ Other (Specify) (emetery 21. ature of Funeral rvice Licensee 22. Name and Address of Fice Benule Smi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque ce Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 12 No Division or Vital 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**1**/No ို 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature a of certifie 29c. License number 29d. Date signed (Month, Day, Year) 08

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death atem 23a) (Type, Print

1604 - Market

31. Date filed (Month, Day, Year) **SEP 1 7 2008**

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32. Restrar's Signature

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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D. 22650 Cedar Lane Court, Leonardtown, Maryland 20650 State 31. Date filed (Month, Day, Year) 32. Faistrar's Signature	ivisio	or Attend ifter death Director: /	rtificati	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	y - At home, farm, s (Specify)		Tes 2 10	28f. Location City or To	(Street and Nur wn, State)	mber or Rural Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 900 Month Day **Physician** a. Arcadia Brewer /Medical 10-01 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Funder 1 Year | Funder 24 Hrs. | Hours | Min. | 4406 Buena Vista Ave 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔭 83 Director 02-28-1925 P.A 216-18-9687 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10h County 10d Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at Yes 2 No Director Baltimore MD the Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nortant: other traumating any liquity or other traumating." 21211 4406 Buena Vista U.S.A. Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2 ☐ No Specify: White Specify. by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 6th 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be Della Arven LOK မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Constance Correlli/Daughter4406 Buena Vista Ave Baltimore MD 21211 20a Method of Disposition | 20b. Place of Disposition (Name of Date | 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 10-3-2008 Riverdale, MD 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State Riverdale Cremtory 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Ronald Taylor II Funeral $H_{ extsf{m}}$ 21. Signature of Juneral Service Licensee Dono 08 W. North Ave Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Robuble Oronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed? Yes 2 No page 5. Wavcase referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Magner of De th 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

within 24 hours after death

To the Funeral Director:
completely filled in by the the 2

> State Registrar

31. Date filed (Month, Day, Year) 2008 0

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

13506

100 Wyman

29d. Date signed (Month, Day, Year)

DB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Jeffrey O. Barber September 25, 2008 6:15 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 5405 Highridge Street Arbutus Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days 219-76-5417 49 Aug. 12, 1959 Maryland Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No MDN/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5515 Patrick Henry Drive 21225 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

12 Yes 2 No 1976If Yes, Give
Year or Dates: 1980 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry System Connections Elementary/Secondary (0-12) College (1-4or 5+) Furniture Installer of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald O. Barber Irene J. Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erika C. Barber - Wife 5515 Patrick Henry Drive, Baltimore, MD 21225 Oa. Method of Disposition 20b. Nace of Disposition (Name of centerry, crematory or other place, 20c. Location - City or Town, State **X**Burial 2 ☐ Cremation 3 Removal from State Loudon Park Cemetery 9-29-2008 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Accident Injury

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

/Medical Examiner attending physician and for use as the burial-tran 68760 Box led by the a Ö ۵. Records, hais page certificate of Vital

the Hospital or Attending Physician: In 24 hours after death.

the Funeral Director: After this certifica npletely filled in by the funeral director, p

Physician/Medical

Completed

Be

Certification: To

3 ☐ Suicide

29a, Certifier (Check only one)

4 Homicide

29b. Signature and title of certifie

30. Name and address of person

6 Could not be determined

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Modical Examinat has be notified at

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event

Ph sician

Baltimore, Maryland 21215-0036

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State 0 2 2008 Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BOOKER SMonth S Physician Day Ye ar 10 AM 300% /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSPITAL MORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, **Funeral** 1 M 2 PF Months Days Hours Min. 908 -52 Torida Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the finding Experience must be multipled at Ame 1 Yes 2 No **Funeral Director** Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Warwickshire 12. Was Decedent Ever in U.S. Armed Orces? 1 Mes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) rogram 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental and 2 should be Health and Menta em 27 is marked 1300 K McChann ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warwickshire John Booker Lane 1 permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sofvice Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) ARCOIDO **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause for the conditions of the conditions Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 1 □ Yes 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 2 🗆 No 2 🖵 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending hin 24 hours after death. the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) DSE BAUTHORE MD ZIZOZ 5 01 ST PAUL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

2008

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 28, 2008 **Physician** 8:15P M Ε. Beavers Neal /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** <u> 28 Alleghany Avenue, Suite 2107</u> Baltimore <u>Towson</u> 8. Date of Birth (Month, Day, Year) April 5,1946 Birthplace (State or Foreign Country)
 Maryland If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Social Security Number Hours 1 M 2 F Days Min 214-44-2404 62 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "netural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "netural", or items 23a emplojury or other treumatic event, the Medical Exemperations. 28 Alleghany Avenue, Suite 2107 21204 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give 1 966-1970 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personnel Officer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Charles Virginia ပ္ Beavers Mary Presson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard M. Turc 9438 Joppa Pond Road Baltimore, Maryland 21234 Brother 20b. Place of Disposition (Name of Cemetery, Ciernatory or other place)
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5 ☐Other (Specify) 10-2-2008 Elkridge Maryland 21. Signature of Fpre rai Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to ur as seonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burlel-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐Yes 2 No 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** GERALDINE MAE BECZKOWSKI /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) cial Security Number (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** 1√ M 2 □ F Months Days Hours Min 077-10-7214 09/16/1917 NEW YORK Director 91 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2X No Director MD. BALTIMORE EASTWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8041 WYNBROOK RD. 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🛣 No Specify WHITE Specify: Completed by 3X Widowed 4 ☐ Divorced "natural" 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 College (1-4or 5+) Elementary/Secondary (0-12) FABRICATOR 12 MACHINE OPERATOR ould be filed w Mental Hygie Is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER WHIPPLE LILLIAN FORBES Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any injury or other trau once. JUANITA CRUM/DAUGHTER-IN-LAW 742 KINGSTON RD., MIDDLE RIVER, MARYLAND 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 09/30/2008 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service License 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Part 1. Ent / the clease, o combilior tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart folium. List the die cause on each line. Approximate Interval Between Onset and Death cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** ona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Certification: To 1 Yes 2 No 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBER 28, 2008 D63054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

A MOID

32. Registrar's Signature

9000

CINA, MD,



FRANKLIN SQUARE DRIVE, BALTIMORE,

21237

Amend PI, #25, per ME g884 10/15/08 TT
Please Type or Print in Black Indelible link. Ensure All Gepies Are Legible.
amend items 23c, 23pt II per doc. g884 uto All Gepies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Brown 12:30 a M 10 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimon Baltmor Genesis icaven och If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State of Foreign Country) **Funeral** Days Min. 1□M 2 F Months Hours 214468570 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show be notified at 1 ¥Yes 2 □ No MD Harford Churchville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with "natural", or items 23a U.S.A. 21028 303 Timothy Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical E once. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lydia Swan Allen Pindell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 303 Timothy Dr. Churchville, MD 21028 Karen Brown/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/2/08 Hanover, MD Ardent Cremation of Funeral Service Licensed Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services 4 Marchall P.0 1413 Baltimore, MD Box 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner CERTIFICATION AND OVED BY MEDICAL EXAMINER wound Sequentially list conditions, if any second to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transi and Due to (or as a consequence Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a t be detached f P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à Coronary Artery Disease,PVD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner?

1 Yes -2 No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: ို 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R113807 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emge Rd. Baltimore MD Nonda 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2008 Registrar 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month **Physician** 44 A M ITLE 0 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City Town, or Location of Death 4c. County of Death Examiner MARYLAND MED ALTIMORE BHCTS/IIUK
If Under 1 Year | If Under 24 Hrs. | Min 8. Date of Birth (Month, Day, May 22, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Sex PMM 2□ F **Funeral** Year) 1932 Months Days Hours 76 Maryland Director 218-28-5823 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shot any Injury or other traumatic event, Its Medical Examinat must be notified at 1 □Yes XX No Director CA Riverside Moreno Valley 10g. Citizen of What Country? United States 10e. Street and Numbe 10f. Zip Code 22940 Mountain View Road 92557 Funeral America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, Black, White, etc. Armed Forces? 1952-1 Never Married Married timore/Maryland 21215-0036 1 □Yes 2XNo Specify: White 1980 If Yes, Give Year or Dates: Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cartographer Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည James M. Butler Angela Marie Reynolds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine E. Butler (Wife) 22940 Mountain View Road, Moreno Valley, CA 92557 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Riverside National Cemetery 12 Surial 2 ☐ Cremation 2 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverside, CA 2008 21. Signature of Fune La rvice Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. An John 11605 Reisterstown Road, Owings Mills, MD 21117 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNGEMIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy Hospital or Attending Physician: The certificate 2 X No 1 ☐ Yes 2 🗷 No of Vital 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 5 Pending injury investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MPI 135648603 2008 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 PLOTNICK GREENE ST. BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 2008

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Amend #22, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #22, PerFH g 884 10/2/08 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SEPTEMBER 30, Year 2008 **Physician** 7:55# CHARLES HENRY BOWERS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE 521 RADNOR AVE. 8. Date of Birth (Month, Day, Year) 7-1-1925 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Min Hours MARY LAND 1 X M 2 □ F 83 220-14-0356 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Mydical Expl. incr., ust be puffind a once. 1 √Yes 2 □ No Director MD. N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21212 521 RADNOR AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: ģ BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BALTIMORE CITY **EDUCATOR** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HATTIE BOOZE WILLIAM BOWERS ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARYLAND 21212 MARJORI, BOWERS (WIFE) 521 RADNOR AVE. BALTIMORE. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 10-7^{at}2008 20a. Method of Disposition 1 Durial 2 Cremation 3 ☐ Removal from State OWINGS MILLS, MARYLAND GARRISON FOREST VETERANS 4 □ Donation 5 □ Other (Specify) D. HIBNER Name and Address of Facility Redd Service HOME, BA. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ir heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e ause (Final disease o ondition resulting in death) in This **Physician** 100 Due to (or a a consequence of): /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed 1+700 attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t autopsy performed certificate 1 ☐Yes 2 ☐No 1 □Yes 2 Wo funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-1-08 MI 1000501 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mi Boersma m. Osler Drive Ste 510 1505 Javid 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2 2008 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician Month 09 Year Hunter 13:31 ames 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Jan. | 2, Baltimore VΑ Medical Center h/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 212-32-7269 Director Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at Maryland N/A Baltimore 1X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 3939 Roland Avenue # 319 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Korea Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Painter General Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James L. Coffey Anna Thompson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Dolly McCauley Daughter 3823 Roland Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 10/1/2008 Glen Burnie, Maryland 5 Other (Specify) 4 □ Donatio Funeral Service License ²² Name and Address of Faculty Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** stroke 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 XYes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P Inpatient 2 □ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18904 9/28/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Slefert Baltimore, MD 21201 Greene St MD 10 N. Suzanne

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

OCT 0 2

2008

Registrar's Signature

			For State Registrar	Otate of Wie	-	ertificate of			2008	3 3 1 4 2 1
	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Emma Decker 4a. Facility Name (If not institution,	give street and number)		4b. City. Town o	r Location of Death	061	4c. County of Deat	
	Exami	er		TOSPITAL		BAL	TIMORE		N/A	
	Funeral Director		5. Social Security Number 218-18-9237 Usual Residence of Decedent	6. Sex 7. Age 1	e (In yrs. last birthda 87 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bird 1920 Ma	thplace (State or Foreign ountry) aryland
	yland		10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	e Mar Ba-f sk	ctor	MD Bal	timore	Ba.	ltimore Hi	ghlands			1 □Yes 2 No
	ath with th	Funeral Director	10e. Street and Number 2927 Ohio Aven	ue			1227		Citizen of What Co	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marked Evanter must be noutful a once.	þ	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
15-(n 72 h i "natu edica	olete	15. Decedent' (Specify only highes		16a. De	cedent's Usual Occup ive kind of work done o e. DO NOT use retired	ation during most of work	ing 16	b. Kind of Business/	Industry
212	d withi giene. er than	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5	(+)	Homemaker			Ov	vn Home
pu	be file ital Hy d othe event,	Be C	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	e (First, Middle, Ma		1
ryla	hould d Men marke matic	다	Lawrence Bury 19a. Informant's Name/Relationsh		10b M	ailing Address (Street	and Number or Clu		ae Beterb	
Ma	alth ar 27 is 27 is er trau		Tanya Milauskas		281	7 New York	Avenue,	Baltimore	e, MD 2122	27
altimore, Maryland 21215-0036	ages 1 a nt of He t: If item	l,	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		Meadowr:	sposition (Name of pernatory ox other place Idge Memor	¥)a1 ≒		c. Location - City or	
alti.	mit. Parantme cortant injury	1	4 Denation 5 Other (Sp	ecify)	Par	rk 22. Name and Addre	10-4-	2008 prose Fund	Elkridge,	, MD . Inc.
ă	Der any	1	(Illune)	THE	NO !	2 71 9 Hammo				
		6	23a. Part 1. Enter the disease, or o shock, or heart failure. List of	only one cause on each lin	ne.	m		or respiratory arres	t,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	LMONA	-1	OLISM			hours
	Examiner	L	Sequentially list conditions,	END	a consequence of): STAGE	RENAL	DISE	45E		YEARS
7	uted I nsit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HEPA	R (N (N	DVCED	THROM	SOCYTOP	ENIA	DAYS
ο, Λ	rtificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last	C	a consequence of):					
68760,	cate b physic the bu	Medical		d						. <u>.</u> .
		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
ords, P.	equires that en signed b ould be deta	ρ	Part II. Other significant condition	ns contributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.		cco use contribute to	o the cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death ce within E4 hours after death. To then E4 hours after death. To the theoret Director. After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Completed						24a. Was an autopsy performe 1 Yes 2	prior to	utopsy findings available completion of cause of
Κ	/sicial s certi ilrecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatie	nt 2 ☐ ER/Outpat	tient 3 🗆 DOA Oth	or:	h (Check only one)	ce 6 ☐ Other (Spe	ant d
ion of	nding Phy ath. r: After thi ee funeral o	ertification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injui (Month, Day	ry 28b. Time	e of 28c. Injur y Work		28d. Describe how		СПУ)
Divis	tal or Atters after des al Directo	Certific	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	ie Hospi 24 hou e Funer letely fill	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	r examination and/oi	eath occurred at the tir r investigation, in my o	me, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner a e and place, and due	s stated. e to the cause(s)
_	To th withir To th comp	Me	29b. Signature and title of certifier	a. A. M.I	<u></u>	29c. Licens			. Date signed (Mont	
			Mallik				257		CT 1St o	
	Le		30. Name and address of person w	JaITIPALLI	STAC	e, Print)	SPITAL	900 S.C.	ATON AU LILMORE	ENU (MD-21229
	Sta Registr	te ar	31. Date filed (Month, Pay, Year)	2008 32. Re gistra	ar's Signature	Inself 1				,

DHMH 17 Rev 1/2001

EMMA

DECKER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LESLIE DENNIS EGENBER. /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner ltimore N/A Date of Birth (Month, Day, Year) 9-12-1950 If Under 1 Year | If Under 24 Hrs 5. Social Security Number Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 ₽M 2 □ F Months Days Hours MARYLAND 217-56-5950 58 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Experiment must be notified at 1 XYes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1542 ARGYLE AVE. 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify Specify: BLACK ò 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the Mark Injury or other traumatic event, the Mark Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) DEPT. OF PUBLIC WORKS BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUTHER SMALL PRIMELEE GRIFFIN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATRINA SINGLE-DENNIS (WIFE) 1542 ARGYLE AVE. BALTIMORE, MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State HOLLY HILLS CEMETERY 10-4-2008 ESSEX, MARYLAND 4 □ Donation Other (Specify) HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part . En er the disease, or complications that caused the death. sho k, o heart failure. List only one cause in each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia e Cruse (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Examine If any, leading to inimediate cause. Enter Underlying Cause (Disease or injury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year 5 Other (specify) ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certification: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

🛘 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:27 P.M September 28, 2008 Edmund A. Ehatt, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Glen Burnie Baltimore Washington Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Funeral 1**⋉** M 2□ F Maryland 76 April 8, **Director** 218**-**28-6467 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination to other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic events. 1 ☐ Yes 2 🔀 No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21060 7250 East Furnace Branch Road by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Anne Arundel County Electrical Inspector 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isabel M. Cannon Edmund Alfred Ehatt, Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1333 Cambria Street; Baltimore, MD 21225 Daughter Amy Brown 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland 10-3-2008 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service bicense 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio Respiratory Arrest /Medical Due to (or as a consequence of): Examiner Fibrilation Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: Box If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) □Yes 2□No sate has been signed by the a page 2 should be detached to P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown History of Lung Cancer Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an History of CHF autopsy death? 2 🖾 No 2 🗆 No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 \(\bigcap \) Nursing Home \(5 \bigcap \) Residence \(6 \bigcap \) Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 XNo Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) o the howithin 2/ To th 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier October 2, 2008 Sul D03607 1011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Hanover Street; Baltimore, MD 21225 M. Cerino, M.D. 3001 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per H G904 6/24/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Y Sept. 29, 2008 Year **Physician** 8:40aM Caroline Elizabeth Foote /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River Ivy Hall Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 312-52-0381 1 □ M 2 1 F 95 Aug. 8, 1913 MD Director should be filed within 72 hours after death with the Maryland montal Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Middle River Baltimore 1 ☐ Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 1423 Third Road USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White <u>^</u> 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12±h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental Alice Pine John Knachel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once. 3646 Hughs Lane Baltimore MD 21221 Harry Foote Jr. / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State MOrelands Memorial 10/2/08 Baltimore MD 4 Donation 5 Other (Specify) gnature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part Enter the distance of complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat first List only one cause heach line. Immediate Cause (Fin Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Vital Physiclan: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 9 within 24 hours are death.

To the Funeral Lirector: After the completely filled in by the funeral 27. Manner of Death 115 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D61907 MDbo, 1124 Mace Avenue Bultimore MD 21221

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene - State Registrar Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 26, 2008 **Physician** 7:11 PM M Renee B. Feldman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 75 1933 Mar 12, New York Director 551-48-1696 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or Items 23a or 28a-f shorevent, the Medical Examiner must be notified at 1 □ Yes 2√□ No MD Montgomery Director Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 4450 S. Park Avenue 20815 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes. Give Specify: white þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) computer programmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Murray Bass Ethel Krout 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Feldman/spouse 4450 S. Park Avenue Chevy Chase, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department o Important: If any Injury or once. ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service State Anatomy Board 655 W. Baltimore Street Director 22/1 Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed attending physician and for use as the burial-transit Sepsis Exami Due to (or as a consequence of): Box 68760, Acute Myocardial Infarction Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I∐Yes 2 ☐ No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Encephalopathy with Seizure Disorder 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 24 No Metastatic Lung Cancer certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes ospital or Attending Physician: Thours after death.
Ineral Director: After this certificat if filled in by the funeral director, pa Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca

9.0 Records, Vital of ision Hospital 24 hours a within 2 To the

> State Registrar

31. Date filed (Month, Day, Year) 2008 OCT 0 2

29b. Signature and title of certifie



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D55148

29d. Date signed (Month, Day, Year)

September 27, 2008

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	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example must be multied at	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?	3. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White		
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Maryland 21215-0036	id 2 sh Ith and 27 is m traum		19a. Informant's Name/Relationsh Joseph E. Mettle		•		N Colum						
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Baltimore,	Page Iment tant: If jury or		1 ☐ Burial 2 🛂 Cremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)	Metr	ro Cre	matory,]	Inc. 10/0	02/2008	Bal	timore,	MD	
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service L	even H. Wil	liams	22	Crematio 299 Fred	ss of Facility n Societ	y of Ma	rylar	nd, Inc.	21228	
رام 1097	Physician and Asician and Phys	cal Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a d. d.	s a conseque	ence of):	er the mode of dyin	ng, such as cardia	c or respiratory	arrest,		Approxim Interval B Onset an	d Peath
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co		g Physician: To the bes Examiner: On the basis and manners	of examinat								e(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEP **Physician** 2008 Paul F. Geppert /Medical BALTIMOR Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPI If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Days 1**X** M 2□ F Months Hours 216-14-7288 87 Director MAy26,1921 MD Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examination in unit of indiffed at MD Baltimore Essex 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1027 Mace Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 XYes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. à SpecifyWhite 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pitt. Plate Glass Handle Dipper 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Howard Geppert Laura Kane မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 of Health a item 27 is 1027 Mace Avenue Baltimore MD 21221 Teresa M.B. Trovato other i 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: if Iter any injury or oth once. 1 Burial 2 Cremation 3 Removal from Sacred Heart of Jesus 10/4/08 Baltimore MD 4 Donation 5 Other (Specify) neral Serv 22. Name and Address of Facility 300 Mace Ave. Balto. Funeral Home of Essex 23a. Party. Enter the disease, of condications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ications that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final MYOCARDIAI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a nonsequence of) The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No o signed by the 9 Unknown 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Record 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1 ☐ Yes Division of Vital Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 2 ER/Outpatient 3 DOA Certification: To Inpatient this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the I within 2 29b. Signature and title of certifie 30. Name and address of person who c npleted cause of death (Item 23a) (Type, Print) PUSHAPDEEP 900 CATON BALTIMORE AVE 32. Registrar's Signature Year, State 2008 Registrar

		ļ	For State Registrar	State of M		partment of F		nd Mental Hy	giene	08 31428
	Physici		1. Decedent's Name (First, Middle, L	HOERL				2. Date of Dea	ath Day	Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g.	ive street and number	_	4b. City, Town, o		Death	4c. County	
	Funeral Director		5. Social Security Number 214–18–5403 Usual Residence of Decedent		ge (In yrs. last birthda) 86 Yrs.		If Under 24		h	9. Birthplace (State or Foreign Country) Mary Land
	Maryland I-f show	tor	10a. State 10b. County Maryland Carrol	11	10c. City, Town or West	Location Minster				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ath with the Marylan 23a or 28a-f show	ai Directo	10e. Street and Number 519 Oak Tree Road	i		10f. Zip Code 21157	7		10g. Citizen of USA	
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show lical Examiner out to natified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces	Ever in U ₂ S. 13 No	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	lispanic Originan, Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)	1	ce - American Indian, ack, White, etc. fy: White
21215-0036	within ene. than *	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12	Education Irade completed) College (1-4or	5+) (Giv	edent's Usual Occup ve kind of work done DO NOT use retired Dational T	during most o d)	1		Business/Industry Business/Industry
Maryland 2	be filed tal Hyg d othe avant,	To Be C	17. Father's Name (First, Middle, Lat William Cosden	st)				s Name (First, Middle, sie A. McCo		те)
e, Mar	s 1 and 2 should of Health and Men item 27 is marke other traumatic		Donna J. Tegele 20a. Method of Disposition		r 519	Oak Tree	Road W	or Rural Route Number Sestminster Date	, MD 21	
altimore,	t. Pages rtment of rtent: If it		1 Metrico di Disposition 1 Metrico di Disposition 1 Metrico di Disposition 1 Cremation 3 1 Cremation 3 1 Cremation 3 1 Cremation 3 1 Cremation 3 2 Cremation 3	cify)	Meadow Br	position (Name of rematory or other place anch Cemeter 22. Name and Addite	y 1	.0/03/08	Westmi	inster, MD
Ba	permi Depa Impo any ii		Thomas Gregor 23a. Part1. Enter the disease, or co shock, or heart failure. List on	Thomas mplications that cause	ed the death. Do not e	301 Frede	rick K		ville,	Maryland 21228 Approximate Interval Between
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a atter	oscleration is a consequence of):	Cardiova	sula	Discus	د	Onset and Death
y.	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter or der, ing Cause (Disease or injury	b. Due to (or a	s a consequence of):					
8760, 2	ate be executed hysician and the burial-transit		that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
.O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	B Ectopic pregnancy Other (specify)	у			ate of delivery onth Day Year
rds, P.	w requires that the de been signed by the s should be detached t	by	Part II. Dither significant conditions Demertia	contributing to death	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did t		attribute to the cause of death? 3 Probably 4 Unknown
Vital Records,		Completed						24a. Was autop perfo		Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott		of Death (Check only		
of	ing Phys After this uneral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of In (Month, D	ury 28b. Time	of 28c. Injur	ryat rk? Yes 2 □ N		dence 6 Ot how injury occu	
Division	al or Attanding s after death. It Director: After id in by the fune	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of II	njury - At home, farm, etc. (Specify)				Street and Num wn, State)	ber or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	edicai (Physician: To the bes aminer: On the basis and manners	of examination and/or					nanner as stated. , and due to the cause(s)
)	To t To t	W	29b. Signature and title of certifier Charles R. A.	ealar J.	m,so	29c. Licens 1) 2	se number			ed (Month, Day, Year) 29, 2008
	4		30. Name and address of person wh	. Lam, M. 1	1001 Ki	e. Print) Heigh	ts tre	+300 Ba	Ito- MI	29,2008
	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 2	112	trar's Signature	Garles				

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State of Manyland / Department of Health and Mental Hygiene

	R	For State	State of Maryland		nent of Hocate of D		ivientai i		teg. No.	008 3147
Physician	1/	. Decedent's Name (First, Mic		_			10.7	2. Date of Dea Month	oth Day Year er 25, 2008	3. Time of Death 0637 hrs
Medical Examine		David I	M. Hildreth		I ₄ h	City, Town, or Lo	ocation of Dea		er 25, 2008 4c. County of E	
	-	Franklin Square Hos				Rosedale	21-10-1			County .
Funeral		. Social Security Number	6. Sex 7. Ag	e (In yrs. last b	irthday)_ I	f Under 1 Year	If Under 24I		irth(MM/DD/YYYY) S	Birthplace (State or oreign
Director	1	216-48-4769	9 XXM 2 F	61	Yrs.	Months Days	Hours N	Aug.	19,1947	Country) DC
	-	Jsual Residence of Decedent		Lia ou T						10d. Inside City Limits
w any	1	0a. State 10b. Coun	timore	10c. City, Tow	n or Location sedale					1 Yes 2 X No
fand once.	ġ_		rimore	KO:		Of, Zip Code			10g. Citizen of What	Country?
or 28a-	Director	0e. Street and Number	ki Highway				1237		USA	
2 8 8 1	_	11. Marital Status	12. Was Decedent	t Ever in U.S.	13. Was E			Specify Yes or N	lo- 14. Race - /	American Indian, Black,
eath w	Funera	1 Never Married 2	Married Armed Forces	? .x. No	If Yes,	specify Cuban,	Mexican, Pue	erto Rican, etc.)	White,	etc.
ifter d	현.	3 Widowed 4 X	Divorced If Yes, Give Year			es 2 X No			Specify:	White
0036 within 72 hours after grene. her than "natural", Medical Examiner	ğ[Specify only highest grade cor			Usual Occupation of working life.			16b. Kind of Busin	ness/Industry •
n 72 h n 72 h nan "r	Set	Elementary/Secondary (0-1	. College (1-4 or	5+)	Carpe	enter			1	
15-0036 filed within 7 Hygiene. d other than the Medica	Completed	12th 17. Father's Name (First, Mid	dle Last)	L		1	8.Mother's Na	ame (First, Middle	, Maiden Sumame)	
215- be filed ntal Hy rked of	B C		Hildreth					na Scot		
D 2121 should be fi and Mental 7 is marked	ᆰ	19a. Informant's Name/Relati	onship (Type, Print)		19b. Mailing A	ddress (Street	and Number	or Rural Route N	umber, City or Town,	State, Zip Code)
e, MD 2 and 2 shoul Health and M item 27 is m		Donna Ryc	kman						Baltimon	ce MD 21237 City or Town, State
IMOFE, MI Pages 1 and 2 nent of Health a ant: If item 2: or other traum		20a. Method of Disposition 1 X Burial 2 Crema	ation 3 Removal from S	20b. Plac	e of Disposition eatory or other	n (Name of cem place)	netery,	Date .	8 Baltin	nty or Town, State
IMOFe, Pages I ar nent of Hes ant: If ite		4 Donation 5 Other	r Specify:	HOT				9/29/0	8 Balti	more MD
Baltimore permit. Pages 1 a Department of He Important: If it injury or other t	- 1	21. Signature of Funeral Serv		1/ 0		ne and Address		300 Mac	e Ave.Ba	alto. MD
		23a. Part I. Enter the disease	occupations that cause	d the death. Do	not enter the	mode of dving.	y Fund	eral Ho	me of Es	t Approximate Interval
Physician 'Medical		failure. List only one ca	use on each line.	V		diovasc				Between Onset and Death
√		Immediate Cause (Final dise or condition resulting in deat	ase a.		TC OUL	<u>arovasc</u>	GLGI D	I.D.C.I.D.C		
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68760, certificate buding physics se as the bu	cian/Me	IF FEMALE: 23b. Was decedent pregnant	in the 23c. If yes, outcome 1 Live birth	ome of pregnar		i death 3	Ectopic pr	egnancy	23d. Date of o	delivery Day Year
c 68 r certif ending use as	ciar	past 12 months?	I EIVO BII (III	at time of death		r (Specify)	cotopio pi	ognano)		,
Box e death c the atten	Physi	1 Yes 2 No 9	3 OHKHOWH	-						
P.O.	by Pi	Part II. Other significant co	enditions contributing to dea	ath but not resu	ılting in the un	derlying cause g	given in Part I.			oute to the cause of death? Probably 4 Unknown
S, P		Sleep Apr	nea					24a. W		/ere autopsy findings available
ords w requas been	ompleted				_			au	topsy	nor to completion of cause of eath?
Reco	mo:								s 2 V No 1	
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate thin 24 burus after death. The Funeral Director: After this certificate has been signed by the attending physimpletely filled in by the funeral director, page 2 should be detached for use as the burus and the burus	Be C	25. Was case referred to me examiner?	4.4				Othor	eck only one)		011-11
Physic rthis	101	1 ✓ Yes 2 No	1	itient 2 🗸 El	R/Outpatient 8b. Time of Inj		ry at Work?	ursing Home 5	Residence 6 be how injury occurre	Other:
n of ding Ph. After t	on:	27. Manner of Death 1 X Natural 5	28a. Date of li (Month, Date		ob. Time of my		Yes 2 No			
SiO Atten r deatl ector: by the	cati	2 Accident	Investigation 28e Place of	Injury - At hom	e. farm. street	, factory, office b	ouilding, etc.	28f. Locatio	n (Street and Number	er or Rural Route Number, City
Division all or Attendin rs after death. all Director: A	Certification:		Could not be determined (Specify)	injury 7 kmom		,,,	3,		n, State)	
lospii 4 hour funer	Š	29a. Certifier 1 Certifyin	ng Physician: To the best of	my knowledge	, death occurre	ed at the time, d	ate and place	, and due to the o	ause(s) and manner	as stated.
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: A completely filled in by the fu	edical	one) 2 • Medical	Examiner: On the basis of e	xamination and	or investigation	on, in my opinior	n, death occur	red at the time, d	ate and place, and d	ue to the cause(s)
		29b. Signature and title of co				29c. Licens				ed (Month, Day, Year)
To with To Com	Me		A A			O.C.	ME		September	25 2008
• • • • • • • • • • • • • • • • • • •	Me	Dum) M, ma			0.0.				
4 3 4 8	Me		erson who completed cause of					MD 04004		20, 2000
$lack \phi$		Donna M. Vincent	i, MD Assistant Med	dical Exami	ner 111			e, MD 21201		20, 2000
$lack \phi$	tate	Donna M. Vincent	i, MD Assistant Med		ner 111			e, MD 21201		20, 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Halley 6:45a.M 2008 09 28 Dessie 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Baltimore Pikesville Milford Manor Nusing Home Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Months Days 1 ☐ M 2 💢 F 92 08 218-22-4142 SC 06 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1X Yes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21207 5209 Bosworth Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes ¾☐No Specify Specify: Black 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5t) nk Elementary/Secondary (0-12) Uniform Factory Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mollie Frank Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 4801 Snader Ave, Baltimore, Md Katie Fleet-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 10/2/08 Baltimore Co, 4 Donation 5 DOther (Specify) Woodlawn of Funeral Service License March For H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Partl. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tie. Approximate Interval Between Onset and Death Immediate Cause (Final lhores disease or condition resulting in death) Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical Examiner

and

physician

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or iry or other traumatic event, the Medical Examinational beauty.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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the Maryland

the burial-tran attending p been signed by the should be detached cate has page 2 s 24 hours after death.
Funeral Director: After this certificetely filled in by the funeral director,

Hospital or Attending Physician; The law requires that the death certificate be executed

certificate

P.O. Box 68760.

Division of Vital Records,

Examiner Physician/Medical ğ Completed Be Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant In the past 12 months? ☐Yes 2☐No 9 Unknown

> 1 □Yes 2 1 No 26. Place of Death (Check only one)

1838 Greene Tue Sel

1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

27. Manner of Death Matural Matural 2 Accident 3 ☐ Suicide

5 ☐ Pending investigation 6 ☐ Could not be determined

es of person

Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 2

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title

npleted cause of beath (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

30. Name and State

31. Date filed (Month, Day, Year) OCT 0 2 2008

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eman 32. Registrar's Signature

Registrar

within 24 hour To the Fune completely file

the

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 30,2008 6:20A CATHERINE NESLINE HORST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Augsburg Lutheran Home Baltimore 9. Birthplace (State or Foreign Mary Land 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth March 6,1917 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2**XX**F Days 217-16-0035 91 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Item 27 is marked other than "natural", or itams 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at 1 Yes 2/7/0 Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 LISA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forence? 1 Yes 20 No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2XNo Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) Cottege (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Ilem 27 is marked othe any liury or other traumatic event, other. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Henry Nesline Margaret Amelia Emge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POA Terry Lee Bond 701 Gittings Avenue Baltimore Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 3 Removal from State XX Burial 2 Cremation Dulaney Valley Memorial Gardens 10/4/08 Timonium Maryland □Donation 5 □ Opher (Specify) ignature of Fune(al/Sevice Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure **Physician** /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months?
1 Yes 2XXNo 5 ☐ Other (specify) the funeral director, page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by aXX_{No} 3 Probably 4 Unknown 1 Tes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X X o certificate 2□ No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check the 29d. Date signed (Month, Day, Year) 29b. Signature and title of central 29c. License number D0053337 September 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dorothy M. Selay MD 25 Main Street Reisterstown MD 21136 Suite 200 31. Date filed (Month, Day, Year) 32. Angistrar's Signature State Registrar 02 2008

		For		State	of Marylan				and Mer	ntal Hygi	iene	0.0	0 1 1 0 0
	7	- State Registrar				Cei	rtificate o	Death	- 10		g. No. 2	0.8	3 432
Physiciar	-	1. Decedent's Name <i>(First</i> LEDNGE		12 £ 1						Date of Death Month	Day	Year Z D D Y	3. Time of Death
/Medica	•	la. Facility Name (If not in			umber)		4b. City, Town	or Location o		17 67 20	4c. County		/) 28
Examine		NIMANTS	WASA	KAL	LENTE	2		ALLST			BAZ	JIMD	nt
Funeral		Social Security Number		/]	7. Age (In yrs.		If Under 1 Yea		24 Hrs. 8. Min	Date of Birth (Month, Day,	Year)	Countr	ce (State or Foreign
Director		215-05-7592		409 M 2 ⊔ F	9	O Yrs.			J	Month, Day, N 12	1918	Mary	land
and	-	Jsual Residence of Deced 10a. State 10b. (County		10c. Cit	y, Town or Lo	cation				-	100	. Inside City Limits
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h the		10e. Street and Number					10f. Zip Code)		10	Og. Citizen of	What Country	?
23a c	<u></u>	439 Green	low I	Road			212					SA	
ILZ 13-UU30 filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ant, the Medical Exeminer must be notified at	runeral Director	11. Marital Status		Armed F	cedent Ever in U.		Was Decedent o If Yes, specify C	f Hispanic Ori; uban, Mexican	gin? (Specify , Puerto Rica	Yes or No- an, etc.)		ce - Americar ack, White, etc	
UUSO nours afte ural", or i	S	1 ☐ Never Married 2 3 🖾 Widowed 4 ☐ D		If Yes, G	2 口 2 3 - 4 Bive Dates: 50 - 6	6	1□Yes 2 X N	o Specify:			Speci	fy: Whi	te
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thin 7.	Completed	(Specify only Elementary/Secondary		de completed College	(1-4or 5+)	life.	DO NOT use reti	red)	or working		_		
ed wii						Clai	ms Adj		r's Nome (F		<mark>Baltin</mark> Maiden Surna		City
e d al p	ă	17. Father's Name (<i>First, i</i> George	Middle, Last,	Itze	1				rgare		alk	me)	
Juan de Marie	<u>∘</u> .	19a. Informant's Name/Ro				19b. Mailir	ng Address (Stre					n, State, Zip C	Code)
≥ 5€2 t		George W.				1.	nglesid						
ss 1 ar of Hear ifem	1	20a. Method of Disposition		1	20b. F	Place of Dispo	sition (Name of matory or other p	elace)	Date		20c. Location	- City or Tow	n, State
allimor rmit. Pages partment of portant: If ite y Injury or o		1 █ Burial 2 ☐ Crer 4 ☐ Donation 5 ☐ C			n State		Forest		9/29/2	800	Owings	Mills	, MD
baltimo		21. Signature of Funeral S	Servise Lice	H	Williams	22	MacNabb 301 Fre	fress of Facility Funera derick	1 Hom Road,	e. P.A Caton	sville	, MD	21228
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/Medical Examiner		resulting in death)		Due to	o (or as a conseq	uence of):							
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ansit ated	Examine	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	" {		(0. 40 4 00.1004								
be executed ician and burlat-transit		that initiated events resulting in death) Last		Due to	o (or as a conseq	uence of):							
icate be executed physician and the burlal-transit	dical		•	d									
ords, P.O. Box 687 requires that the death certificate een signed by the attending physi nould be detached for use as the I	ğ -	IF FEMALE:		ODO If you o	utcome of pregna								
BOX 62 eath certific attending p for use as i	Physician/Me	23b. Was decedent pregr in the past 12 month		1 🗆 Live	e birth 2 Peta egnant at time of	Ideath 3[☐ Ectopic pregna ☐ Other (specify					ate of deliver fonth E	y Day Year
the d) sic	1 □ Yes 2 □ No 9 □ Unknown		9 Uni		1000 J							
s that	by Pr	Part II. Other significant	conditions	contributing to	death but not res	ulting in the u	nderlying cause	given in Part I		23e. Did tol	pacco use co	ntribute to the	cause of death?
en sig										1 □ Ye	es 2 No	3 ☐ Proba	bly 4 Unknown
HECORGS The law requires The has been signing to be a should be	Completed									24a. Was a			sy findings available pletion of cause of
The law cate has be page 2 sl	5									perforr	ned? 2 No	death? 1 □ Yes 2	No
Vital ician: 1 certifical ector, pa	e Re	25. Was case referred to examiner?	medical	Hospital:				Othor:		Check only on			
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on ding th. : Afte	[]		Pending investigatio	(Mc	onth, Day, Year)	Injury		njury at Vork? □Yes 2□	1		, ,		
INISION Or Attending after death. Director: Afte	Certification:		Could not be	1 28e. Plac	ce of Injury - At h Iding, etc. (Speci	ome, farm, sti	reet, factory, offic	e	28f.	Location (Si		nber or Rural	Route Number,
tal or rs after all Dir	Sel												
	edical	29a. Certifier 1 Check only one)	ertifying P Medical Exa	miner: On the	he best of my kno basis of examina anner stated.	owledge, dea ation and/or in	th occurred at the ovestigation, in n	e time, date a ny opinion, dea	nd place, and ath occurred	d due to the d at the time, d	ause(s) and late and place	manner as sta e, and due to	ated. the cause(s)
To th Within To th comp	Me	29b. Signature and title of	f certifier					ense number	,		9d. Date sign		- /
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20 +1		30. Name and address of	f person who	completed ca	use of death (Iter			AMOAL	LSS m	wr. m	0 7	1132	
Stat	e	31. Date filed (Month Da	7, Yearb	2008 32	legistrar's Signa		9 40		/ V ·)	- 1	1/-/	
Registra	r		N	100	September 1	So Son	ABAGE!						

		-	For State Registrar		State of	Marylan			of Health and of Death	Mental Hy	giene Reg. No. 2	008	31433
	Physicia /Medic		1. Decedent's Name		,					2. Date of Do Month	Day	Year 2008	3. Time of Death
	Examin	er	Jo Vvv tovi 5. Social Security Nu	Kins BA		/		Balti.		ith	4c. Co	9. Birth	place (State or Foreign
	Director		215-64- Usual Residence of		1 ⅓ M 2 □ F	54	Yrs.	Months Da	ays Hours Mir	8. Date of Bi (Month, D Oct. 2	8,1953	3 Mar	yland
	e Maryland la-f show	ctor	10a. State	10b. County			y, Town or Lo ltimor						10d. Inside City Limits 1 Yes 2 No
	with the	Director	10e. Street and Num					10f. Zip Co	de 21224			n of What Cou	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modral Evancher List by multihal at once.	by Funeral	216 N. R 11. Marital Status 1 □ Never Marrie 3 □ Widowed	ed 2 Marrie	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give	es 2√2 No _			of Hispanic Origin? (Cuban, Mexican, Pue	(Specify Yes or N irto Rican, etc.)	0- 14	. Race - Amer Black, White, pecify: Whi	ican Indian, etc.
21215-0036	within 72 hour lene. 'than "natural	Completed I	(Speci	15. Decedent's ify only highest			(Give	dent's Usual O kind of work d DO NOT use re	one during most of w	orking	10	of Business/Ir	-
land 2	should be filed vand Mental Hygies marked other is marked other is umatic event, to	To Be Co	12 17. Father's Name (R.B. Joh		ast)		1343	OLCI	18. Mother's Na Caroly	ame (First, Middle n Koeth		urname)	
, Maryland	1 and 2 shou Health and N tem 27 is mar other traumat		19a. Informant's Na Roxanne						reet and Number or I	altimore			ip Code)
Baltimore,	Pages 1 ament of He ant: If Item		20a. Method of Disp 1 ⊈Burial 2 □ 4 □ Donation	Cremation :	3 ☐ Removal from St ecify)	ate Cr	emetery, ciei est La ardens	sition (Name of natory of other WN Memo	riai 8	OCCC 3	Marr	ition - City or T iottsvi	lle,MD
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Full	neral Service	Lich_		22	2. Name and A	ddress of Facility R Baltimore				Home, P.A. 224
	Physician /Medical		23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List o Final		sed the death h line.	1	er the mode of	f dying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list cor dary, leading to man cause. Enter Under Cause (Disease or	nditions,	b. Multi			avo fai	lure				2days
)	xecuted and al-transit	Examiner	Cause (Disease or that initiated events resulting in death) L		c. IVYCC	as a consequ	uence of):					-	Iweek
68760,	ficate be ex physician as the burial.				d. liver o								5 years
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		th 2 ☐ Feta nt at time of o	1 death 3[☐ Ectopic preg ☐ Other <i>(speci</i> i			23	d. Date of deli Month	very Day Year
rds, P.	es tha igned be de	þ	Part II. Other signif	icant condition	ns contributing to dea	h but not res	ulting in the u	nderlying caus	e given in Part I.			e contribute to	the cause of death?
I Records,	The ate h	Completed									opsy formed?	24b. Were au prior to d death? 1 □ Yes	topsy findings available completion of cause of
Vital	Physician: The rthis certificate ral director, pag	Be (25. Was case referr examiner?	,	Line-itel.					eath (Check only			
of	ilng Phys 1. After this funeral dir	ion: To	1 ☐ Yes 2√2 27. Manner of Death 1 ☑ Natural	h 5 🗆 Pending	28a. Date of (Month)		ER/Outpatie 28b. Time o Injury	nt 3 DOA f 28c.	Injury at Work?	Home 5 Re			cify)
Division	Atten deat ctor: by the	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investiga 6 Could n determin	ot be 28e. Place o	Injury - At ho , etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, of	1 ☐ Yes 2 ☐ No		(Street and own, State)	Number or Ru	ral Route Number,
	lospita 4 hours uneral ely fille	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	g Physician: To the be examiner: On the bas and manne	is of examina	owledge, deal	h occurred at to	he time, date and pla my opinion, death oc	ace, and due to the courred at the time	ne cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
	e e e e	-											
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral Director Funeral Director Funeral Director Funeral Director Funeral Director Funeral Director Funeral Funera	Me	29b. Signature and	title of certifier				29c. Li	cense number		29d. Date	signed (Month	n, Day, Year)

State

Registrar

DHMH 17 Rev 1/2001

4940 Eastern Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-07291 Lucretia Jordan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 25, 2008 0720 hrs cal Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Good Samaritan Hospital 9. Birthplace (State of Foreign 8. Date of Birth (MM/DD/YYY) If Under 1 Year If Under 24Hrs: 5 Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Months Days 4 land Director Country) 2 **X** F M Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location Yes 2 No i 23a or 28a-f show i notified at once. or 28a-f show Director 10g. Citizen of What Count 10f. Zip Code 10e. Street and Number 21207 100 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes Specify: Black Yes 2 No specify: If Yes, Give Year Widowed Divorced other than "natural", the Medical Examiner 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) timore, MD 21215-0036

it. Pages 1 and 2 should be filed within 72 hou mirront of Health and Mental Hygiene.
refaut. If item 27 is marked other than "nat y or other tranmatic event, the Medical East y or other tranmatic event, Elementary/Secondary (0-12) GED Mother's Name (First, Middle, Maiden Surname 17, Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address ina 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, permit. Pages 1 a
Department of He
Important: If it
injury or other t crematory or other place, X Burial 2 Cremation 3 4-2008 Donation 5 Other Specify Name and Address PAFacility

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Cullud Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or **Physician** Between Onset and failure. List only one cause on each line 'Medical Death Hypertensive Cardiovascular Disease Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical attending physician a for use as the burial - 1 AMENDED 23a,27 per me g884 10-17-08 vt X UNPENDED Division of Vital Records, P.O. Box 68760, 23d, Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Month Day Year 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ج</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of s certificate has b rector, page 2 sh performed? death? 1 🗸 Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical fo the Hospital or Attending Physician: Be examiner? Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other this ۲ 1 ✓ Yes No Director: After the fin by the funeral 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 X Natural Yes 2 No within 24 hours after death.

To the Funeral Director: Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME September 26, 2008 O.C.M.E. and address of person who completed cause of leath (Item 28) orperd Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Second Security Number 10 20 25 10 20 25 10 20 25 10 20 25 10 20 25 10 20 25 10 20 25 10 20 20 20 20 20 20 20			For State Registrar		С	ertificate of	Death		eg. No. 200	0 3143
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The companies of the control of th			i. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	(Month, Day,	Year) (Country)
MD Baltimore Essex 10/25 code 10/2		-	Jsual Residence of Decedent			Location		pune /	, 1920	
13. Marcial Shalus 12. Was Dependent Even in U.S. 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. American inclaim, 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. American inclaim, 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. American inclaim, 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. American inclaim, 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. American inclaim, 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. American inclaim, 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. White, etc. 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. American inclaim, 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. White, etc. 13. Race. American inclaim, 13. Was Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. White, etc. 13. Race. White, etc. 13. Race. White or Dependent of Hispanic Origin? (Specify Yos or No. 12. Race. White, etc. 13. Race. White, etc. 13. Race. White, etc. 13. Race. White or Dependent of Hispanic Origin? (Specify Yos or No. 13. Race. White or Dependent of Hispanic Origin? (Specify Yos or No. 13. Race. White or Depondent of Hispanic Origin? (Specify Yos or No. 13. Race. White or Disposition Origin? (Specify Yos or No. 13. Race. White or Disposition Origin? (Specify Yos origin.) (Specify Yos origin.) (Specify Yos origin.) (Specify Yos origin.) (Specify Yos origin.) (Specify Yos origin.	-			more	100. 00, 1000 0	_				1 □ Yes 2 □
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18. Method of Deposition 19. Informatic Name (First Middle, Masiden Surname) 19. Informatic Name (First Middle, Masiden Surname) 19. Informatic Name (First Middle, Masiden Surname) 19. Informatic Name (First Middle, Masiden Surname) 19. Informatic Name (First Middle, Masiden Surname) 19. Informatic Name (First Middle, Masiden Surname) 19. Informatic Name (First Name (Firs	Palaton	elaic	(Specify only highest of	rade completed)	(G	ecedent's Usual Occup tive kind of work done fe. DO NOT use retire	oation during most of world)	king	16b. Kind of Busines	s/Industry
The part is of the significant conditions contributing to death but not resulting in the underlying cause given in Part i.	-	<u> </u>	8th		HO!	memaker			own	home
138. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVely Schofield / daughter 139. National Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ő	O C							Maiden Surname)	
200. Method of Disposition 2 Committee	F		19a. Informant's Name/Relationship	(Type. Print)	19b. M	ailing Address (Street	and Number or Ru	ral Route Number	City or Town, State	, Zip Code)
Source Secretarion Secretario				Tera /dau	20b. Place of Di	sposition (Name of				
Connelly Funeral Home of Essex 21221					Oak La	awn Cemet	ery 9/2	7/08	Baltimo	re MD
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The stand of the s			23a. P. t1. Enter the disea e, or co	p ications that cause v one cause on each	e death. Do not					
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The state of the significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1 Yes 2 No 3 Probably 4 Unk	7	ari/Medic	23b. Was decedent pregnant			3 ☐ Ectopic pregnance	74		23d. Date of c	lelivery
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Cheng MD 4940 Eastern Avenue Buttimore, MD 21224	Cortification: To Do Completed by Bhysician/Modical	certification: To be completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier Check only Check only Check delical Ex	Hospital: 28a. Date of Injudenth, Date of Injudenthy,	2 Fetal death t time of death ut not resulting in th ent 2 ER/Outpa try y, Year) 28b. Tim Injury - At home, farm, c. (Specify) of my knowledge, dif examination and/o	e underlying cause give titient 3 □ DOA Other (Specify) = 28c. Injury M 1 □ street, factory, office	26. Place of Dea er: 4 □ Nursing H ry at k? Yes 2 □ No	24a. Was an autops perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe house 28f. Location (St. City or Town	Month pacco use contribute as 2 No 3 part 24b. Were prior to death 1 Ye pacco use contribute as 2 No 3 24b. Were prior to death 1 Ye pacco use contribute A contribute of the contribute	Day Year to the cause of death' Probably 4 Unknot autopsy findings availa o completion of cause es 2 No pecify) Rural Route Number, as stated.
Jennifer Cheng MD 4940 Eastern Avenue Buttimore, MD 21224	Portification: To De Completed by Obygion/Madical	ledical Certification: 10 be completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati 3 Suicide 6 Could not determine 29a. Certifier (Check only one)	Hospital: 28a. Date of Injudenth, Date of Injudenthy,	2 Fetal death t time of death ut not resulting in th ent 2 ER/Outpa try y, Year) 28b. Tim Injury - At home, farm, c. (Specify) of my knowledge, dif examination and/o	e underlying cause give titient 3 □ DOA Other (specify) = e underlying cause give titient 3 □ DOA Other of the street, factory, office eath occurred at the tip investigation, in my office the street, factory and the street of	26. Place of Dea er: 4 Nursing H ry at k? Yes 2 No me, date and place opinion, death occur se number	24a. Was at autops perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe how 28f. Location (St. City or Town 2, and due to the corred at the time, d.	Month pacco use contribute as 2 \(\text{No} \) 3 \(\text{Description} \) and 24b. Were prior to death 1 \(\text{Vertex prior} \) and 2 \(\text{Description} \) and 3 \(\text{Description} \) and 4 \(\text{Description} \) and 6 \(\text{Other} \) (Special control of the prior to th	Day Year to the cause of death? Probably 4 Unknot autopsy findings availa o completion of cause? es 2 □ No Decify) Rural Route Number, as stated, ue to the cause(s)
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			For State Registrar		State o	f Marylan		artment of F rtificate of			lental Hy	giene Reg. No. 2	008	3	1436
	5	-	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tir										3. Tim	e of Death	
	Physici /Medic		Ve	ena	M. Li	.рру					Septer	nber 2	3, ຊື່ <u>ດ</u> ື້ດ	8 7:3	55 a ^M
	Examin				give street and num sing Home			4b. City, Town, o		of Death	•	4c. County of Death Baltimore			
	Funeral		5. Social Security	Number		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under		8. Date of Bi	ate of Birth 9 Birthplace (State or Foreign			ate or Foreign
	Director		246-28-7	7487	1□M 2 - F	81	Yrs.	Months Days	Hours	Min.	Feb.	3, Ye <i>ar)</i>	7 Nor	th Ca	rolina
	w w		Usual Residence of	of Decedent 10b. County		10c. Cit	ty, Town or Lo	ocation						10d Insid	e City Limits
	Maryla f sho ied at	ō	MD		imore		Tows								Yes 2 No
	r 28a-	Director	10e. Street and Nu	umber			31	10f. Zip Code				10g. Citizen	of What Cou	untry?	
	th with	alD	810 Etc	on Road			21 204				:	U.S.A.			
	tems er mt	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U.	er in U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto				ecify Yes or N Rican, etc.)	0- 14.	Race - Amer Black, White		٦,
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Fi	1 ☐ Never Mar 3 ☐ Widowed	rried 2⊠ Marrie 4 □ Divorced	d 1 ☐ Yes If Yes, Giv Year or Da	/e	1□Yes 2☑No Specify: Specify: White								
9	2 hou atural cal Es	ted t		15. Decedent's	Education	4103.	16a. Decedent's Usual Occupation 16b. Kind of Busine								
215	thin 7, e. an "n Medi	Be Completed	Elementary/Sec		grade completed) College (1	-4or 5+)	1			uring most of working					
7	led wi lygien her th nt, th	Cou	12	(F) 1 AC 1 (1)	College (1		Execu	utive Sec				1	catio	Π	
and	d be fi		17. Father's Name	, , ,	_{asi)} Spea	ke				ers Name Lala	(First, Middle		rname) L lin qs		
T.	shouk nd Me mark mark	은	19a. Informant's N				19b. Mailii	ng Address (Street			al Route Numl			ip Code)	
N N	alth a		Francis					Eton Rd.				204	,, _	,	
Baltimore, Maryland 21215-0036	es 1 a of He f item or othe		20a. Method of Dis		3 □Removal from	20b. F	Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)		Date	20c. Locati	on - City or 1	Γown, Stat	Э
Ë	Pag tment tant: I		4 □ Donation	5 Other (Sp	ecify)	Hil		Gervice C			02/08		on, MD		
Ball	permit. Pages 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		21. Signature of F	uneral Service	^{ensee} Willi	am G. D)au 23	2. Name and Addre	Rd/,	ity Rucl Tows	k Towso	on Fune 2120	eral Ho 14	ome,	inc.
	7.E T		23a. Part1. Enter shock, or he	the disease, or cart failure. List o	omplications that conly one cause on e	aused the deat	h. Do not en	ter the mode of dyir	ng, such as	cardiac o	or respiratory a	arrest,		Approxi	Between
	Physician		Immediate Cause disease or condition	(Final on	1920	u~6								Onset a	and Death
	/Medical Examiner		resulting in death)	- 1	Due to (or as a conseq	uence of):								
23		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dauss (Unsease or Injury that initiated events												
\checkmark	cuted ad ransit	Examiner	cause. Enter Und	erlying r injury ts	C.										
90,3	cate be executed physician and the burial-transit	EX	resulting in death)	Last	Due to (or as a conseq	uence of):								
5 Am 68760,	physic	dical		`	d										
7:35 Box (nding use a	n/Me	IF FEMALE:	nt pre-mant	23c. If yes, out							23d	. Date of deli	verv	
L B	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	23b. Was decedent pre-mant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 No 9 Unknown 9 Unknown								Month	Day	Year		
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Vital	an: T tificat tor, pa	Be Co	25. Was case refe	rred to medical					26 Place	a of Death	1 ☐ Yes	2 No	1 ☐ Yes	2 ₹No	
	> .50 0	TO B	examiner? 1 ☐ Yes 2 🗹	No	Hospital: 1 □ I	npatient 2	ER/Outpatier	nt 3 DOA Oth			me 5□Res		Other (Spec	eify)	
000	ding Phys I. After this funeral di	:uo	27. Manner of Dea	ith 5 Pending	28a. Date of (Mont	of Injury th, Day Year)	28b. Time o Injury	f 28c. Injur Wor			28d. Describe				
	ttend death. stor: /	cati	2 ☐ Accident 3 ☐ Suicide	investiga 6 □ Could no	t ho	of injury. At he			Yes 2		2011				
Div	al or A after I Direct d in by	Certification:	4 ☐ Homicide	determin	ed 28e. Flace buildii	ng, etc. (Specif	y)	eet, factory, office			28f. Location (City or To	Street and N wn, State)	umber or Hu	rai Houte i	Number,
9/25/08 Vena Division or		Medical C	29a. Certifier (Check only one)	1 CertifyIng 2 Medical E	Physician: To the xaminer: On the ba	asis of examina	wledge, deat tion and/or in	h occurred at the til vestigation, in my o	me, date a opinion, de	nd place, ath occurr	and due to the red at the time	cause(s) an , date and pla	d manner as ace, and due	stated. to the cau	se(s)
29d. Date signed						igned (Month	, Day, Yea	ar)							
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	10		J. Name and add	2 JK	ho completed cause	2 Z	1 D	ad Ton	son	M	0 21	204	`		
	Sta Registra		31. Date filed (Mor	hith: Peyr Year)	2008 ^{32. R}	gistrar's Signa	ature	best							
					-		- 27								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 20a-c per fh g884 10-2-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 6:25 RM **Physician** october Adelina 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner C, A Ban 4 more 74 onewood Genesis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F 59 Jan 1. 1949 **SUDAN** 214-81-2114 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits the Maryland 10a. State 10b. County or 28a-f show notified at 1 Yes 2 No N/A Baltimore Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or ? must be n Pages 1 and 2 should be filed within 72 hours after death with 21212 **SUDAN** 5544 Lothian Road, Apt #1 Completed by Funeral 14. Race - American Indian items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: ō Specify: Sudanese Baltimore, Maryland 21215-0036 3 ₩idowed 4 Divorced "natural" 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown by Informant 0dur Lim 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 19a. Informant's Name/Relationship (Type. Print) 5544 Lothian Road, Apt #1, Baltimore, Maryland (Son) Peter Ochan F. Abore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Mem. Garden 10-6-08 Timonium, Md. 4 Donation 5 Dother (Specify) 21. Signatur M. Funeral Service Lidensee

Martin D. Lawson Name and Address of Facility FUNERAL HOME, 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Anon xio-/Medical Due to (or as a consequence of): Examiner 1 year Meninsioma Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physiclan: The law requires that the death certificate be execute nding physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760) Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Pul minar 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Kaltin autopsy performed 1□ Yes 2 No 2. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Avursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after deau. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D3/395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Klow MO isalt mid 5 707 Kenwand KISTE 31. Date filed (Month, Pay, Year) 32. gistrar's Signature State 2008 Registrar

08-07386 Mickey Lippy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 31438

		1- For State Registrar	Cer	tificate c	of Death			Reg. No.	
Physicia	an/	1. Decedent's Name (First, Middle,	· ·			-40	2. Date of De Month	Day Year	3. Time of Death
edical Exami	ner	Mickey Charle	-,		4b. City, Town,	or Location of C		er 28, 2008 4c. County of D	0140 hrs
		4a. Facility Name (if not institution, Walker Mill Regional Pa	-		District H		Death	Prince Geo	
Funeral	7,6		5. Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Y		24Hrs. 8. Date of E	Birth(MM/DD/YYYY) 9.	
Director		213-78-7785	XX M 2_F	34 Y		ays Hours	Jan.	7, 1974 FG	oreign Country)Maryland
		Usual Residence of Decedent	-2.						- int j tailo
, any		10a. State 10b. County	10c. City,	Town or Loca	ation				10d. Inside City Limits
Maryland 28a-f show datonce.	ō	Maryland Carro	11 Wes	stmins	ter				1 Yes XX No
Maryl 28a-	Director	10e. Street and Number	•		10f. Zip Code			10g Citizen of What (United Sta	Country?
ith the Maryland 23a or 28a-f sho notified at once,		1482 Allen Way			211			of America	
death wi	Funeral	11. Marital Status1 Never Married 2XX Married	12. Was Decedent Ever in U. Armed Forces?				? (Specify Yes or I Puerto Rican, etc.)	No- 14. Race - A White, et	merican Indian, Black, ic.
ter dea			1 Yes XX No	1	Yes XX	No specify:		Specify: W	hite
. hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once	d by	15. Decedent's Education (Specif	or Dates:		ent's Usual Occu	pation (Give kir		16b. Kind of Busine	ess/Industry
64 a 🗖	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Law Enforcement Maryland State							
5-0036 fled within 72 Hygiene. I other than "	ᇤ	Trooper & Flight Medic Police Depart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)							
21215-C uld be filed v Mental Hygi marked oth, c event, the I		17. Father's Name (First, Middle, L Herbert Bruce L	·				Name (First, Middle a Newberr		
2121 uld be fi Mental marked c event,	o Be	19a. Informant's Name/Relationshi		19b. Maili	ng Address (Si	1		umber, City or Town, 5	State, Zip Code)
sho sho	-	Christina E. Li	ppy (Wife)	1482	Allen V	Way, Wes	stminster	, Maryland	3 21157
_ = = = «		20a. Method of Disposition	20b.	Place of Disp	osition (Name of	cemetery,	Date Oct. 3,	20c. Location - Cit	
Pages ent of		4 Donation 5 Other Spe	3 Removal from State Du	rematory or i Taney morial	Välley Gardens		2008	Timoniu	m, Maryland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1	21. Signature of Fund al Service L					1 Chapel,		
മ ഉള്ള്	2	116/-20	blandt	- 11	1605 Re:	isterst	own Road,	Owings Mi	11s, MD 21117
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause of	n each line.	i. Do not ente	r the mode of dyi	ng, such as car	diac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consequence of	· n.					Death
		Sequentially list conditions,	b.	л). 		·			
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	of):		3.1			
11%	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):			1945		
cuted and transi		,	d						
760, icate be executed physician and the burial - trans	/Medical	UNPENDED	AMENDED						_
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		C-4-1 death	3 Ectopic	orognana(23d. Date of de Month	
ox 687 eath certifi attending for use as t	ciar	past 12 months?	4 Pregnant at time of de	ooth	Fetal death Other (Specify)	3Ectopic	oreginancy	World	Day Year
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician	1 Yes 2 No 9 Unkn	9 CHKHOWH					940	
P.O.	by P	Part II. Other significant condition	ins contributing to death but not r	resulting in the	e underlying cau	se given in Part			te to the cause of death? Probably 4 Unknown
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cords law requi has been 2 should	Completed	γ					au		or to completion of cause of
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tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner?	Hospital:	1		Othor	Check only one)	7	
of Vital Records, ng Physician: The law requir witer this certificate has been s meral director, page 2 should I	ပ	1 Yes 2 No 27. Manner of Death	Inpatient 2	ER/Outpatie		Injury at Work?	Nursing Home 5	Residence 6 🗸	
_ = <u>-</u> - ≥ =	ion:	1 Natural 5 Pendi	(Month, Day Year)	0042 hrs	· · · _	Yes 2	Passenne	er in helicopter cr	
Division tal or Attendi rs after death. al Director: //	ficat		igation 28e. Place of Injury - At h	nome, farm, st	reet, factory, offi	ce building, etc.	28f. Locatio	n (Street and Number	or Rural Route Number, City
Division of Vital I Hospital or Attending Physician: 24 hours after deathad Femeral Director: After this certifi etely filled in by the funeral director,	Certification:	Suicide 6 Could 4 Homicide determ	not be inined (Specify) Woods				or Town Walker Mill	n, State) i Regional Park, Dis	trict Height, MD
= 2 = 5		29a. Certifier 1 Certifying Phy	ysician: To the best of my knowled	dge, death oc	curred at the time	e, date and plac	e, and due to the c	ause(s) and manner as	s stated.
To the Ho within 24 h To the Fu	edical		niner: On the basis of examination a and manner stated.	and/or investi			urred at the time, da		
	Σ	29b. Signature and title of certifier	1.			cense number			(Month, Day, Year)
		fairle!	negus		0.	.C.M.E.		September 2	.5, ∠000
n_O		30. Name and address of person variable Tasha Greenberg MD.	who completed cause of death (Iter Assistant Medical Exan	-	1 Penn Stre	et Baltimor	e, MD 21201		
	tate		2. Registrar's Signat						
Regis		31. Date filed Month, Day, Year)	008 January 13	Logi	Es .				

			State of Maryland / Department of Health and Mental Hygiene
			1- State Registrar Certificate of Death Reg. No. 000 3 1439
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death BALTILORE ACCOUNTY OF DEATH
- 0	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent
	Marylan I show	tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 ▼No
	with the a or 288	Direc	10e. Street and Number 923 Courtney Road 10f. Zip Code 110g. Citizen of What Country? United States
	death ms 23	neral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23e or 28a-f show onjant: If item 27 is marked other than "natural", or Items 23e or 28a-f show injury or other traumatic event, the Madical Examinar must be notified at the 48.	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give Year or Dates: Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Ricán, etc.) 1 Yes, Specify: Black, White, etc. 1 Yes, Specify: Specify: White
15-0	"natu	letec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
212	d withii giene. ir than Ine M	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home
Maryland 2	2 should be filed withir and Mental Hygiene. ia marked other than aumatic event, the Ms	To Be C	17. Father's Name (First, Middle, Last) John Arnold 18. Mother's Name (First, Middle, Maiden Surname) Emma Thomas
Mary	and 2 should salth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Type, Print) John E. Menard - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 Courtney Road, Halethorpe, MD 21227
ore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		20a. Method of Disposition 20b. Place of Disposition (Name of Medical Control of Medical
Baltimore,	permit. Pages Department of I Important: If it any injury or o		Park 10-2-2008 Elkride, MD
Bal	permit. Departr Imports any inju		22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227
	4.09		23a. 1 m. Enter the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Conquisited feat failure (MO nTh
	/Medical Examiner		Due to (or as a porise quence or):
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
_	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):
760,	te be e. ysician ie buria	cal	d
68	artificat ing phy e as th	Med	IF FEMALE:
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 points? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown 1 Year 1 Yes Year 1 Yes Year 1 Yes Year 1 Year Ye
0	uires that r signed by ld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 16 3 Probably 4 Unknown
Records,	rsician: The law requires contilicate has been si lirector, page 2 should I	Completed	24a. Was an autopsy perfor to completion of cause of death?
of Vital	ding Physician: The In. After this certificate hat funeral director, page	Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
of V	Physician: r this certificatal director,	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Invising Home 5 Residence 6 Other (Specify)
	th. th: After funera	tlon	27. Mann of of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Sec. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred Now injury occurred 1 Now injury occurred 1 Yes 2 No
Division	al or Attendii safter death. I Director: A d in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To ti Withi To ti	M	29b. Signature and title of certifier Pain S. Kalphuem ND 29c. License number 29d. Dafe signed (Month, Day, Year) 9/29/09
	U		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANI S. KARIPINENI
	Sta Registi		31. Date filed (Month, Day, Year) 32. Segistra's Signature 32. Segistra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 **Physician** 2005 Treem /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Ark TIM If Under 1 Year | If Under 24 Hrs . Age (In yrs, last birthday) holace (State or Foreign **Funeral** 8 Months Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Pres 2 □ No Funeral Director erand Number 10g. Citizen of What Country? 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No Specify. <u>ک</u> 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. nt: If Item 27 is marked other than ' Elementary/Secondary 0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) le mak 0 19a Informant's Name/Relationship/(Type. Print 19b. Mailing Address (Street and Number or Rural Route Mimber, City,or Town, State, Zjp Code) permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition gemetery, crematory Method of Disposit 1 Burial 2 Cremation 3 | Removal from State 4 □ Donation 5 □ other (Specify) 21. Signature of Funefal Service Licensee 23a. Part1. Enter the disease, or complications that caus a shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL Physician INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dunknown Be Completed been DiALoles 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has page 2 autopsy performed hypercholesterns 1□ Yes 2 No or Attending Physician: 25. Was case re red to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 □ No 2 Accident after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral I 1 Elertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

PARK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE

32. Registrar's Signature

HEIGHTS

2008

DHMH 17 Rev 1/2001

29c. License number

1) 3037

ROBERT M. COOPER MP

21215

29d. Date signed (Month, Day, Year)

08-07225									
Lisa	С	Martin							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 31441

	1- For State Registrar	Certif	ficate of L	Death		Reg	. No.	
Physician/ Medical Examine	1. Decedent's Name (First, Middle,	Lisa Martin	,		1	Date of Death Month September		3. Time of Death 1208 hrs
	4a. Facility Name (if not institution, 1102 Druid Hill Avenue			. City, Town, or Lo Baltimore	cation of Death	,**	4c. County of Dea	//A
Funeral Director	214-72-0664	Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. E 1965	Sirthplace (State or eign Country) Mary and
te Maryland or 28a-f show any fied at once.	Usual Residence of Decedent 10a. State 10b. County May land 10e. Street and Number	VA	own or Location	Ba,	Himore	100	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
with the ns 23a be noti			13. Was	Decedent of Hispa s, specify Cuban, N			14. Race - Am White, etc	erican Indian, Black,
	3 Widowed 4 Divor	,	6a. Decedent's	Yes 2 No s Usual Occupation st of working life. D	n (Give kind of v		Specify: 16b. Kind of Busines	White s/Industry
2 "= 0	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L	College (1-4 or 5+)		Disabl-		e (First, Middle, M	aiden Surname)	1
21 be fil ntal I rrked ent,	UKNOWN		10h Mailing	L	inknow.		per, City or Town, St	ate Zin Code)
MD and 2 sho shift and 2 sho salth and 27 is aumati	Angelic Carte 20a. Method of Disposition	r-friend	1571 1	Argyle ion (Name of ceme	Ave. E	Battimor	e Mante 20c. Location - City	ind 412-17
Baltimore, permit. Pages 1 a Department of He Important: If ite	1 Burial 2 Cremation 4 Donation 5 Other Spe 21. Signature of Funeral Service L	city: Me	ematory or other	er place)	M 9	26/08 Ser Fun	Catons Vi	The Maryland
Physician	23a. Part I. Enter the disease, or confailure. List only one cause o	omplications that caused the death. Don each line.	o not enter the	e mode of dying, si	uch as cardiac o	or respiratory arre	st, shock, or heart	pproximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Narcotic intox Due to (or as a consequence of):	<u>icatio</u>	n .				Death
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarking Court (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):		mt i				
execut ian and ial - tra		d. X AMENDED #14, per 23a,27,	FH g8 28a-f,	84 10/2/ perME, 8	08 TT 2884 10	/15/08 T	T	
). Box 68760, the death certificate be by the attending physic by the attending physic physician Mec	= 123b. was decedent brednant in the	23c. If yes, outcome of pregna 1 Live birth 4 Pregnant at time of deat	ncy 2 Feta		Ectopic pregn		23d. Date of deli Month	very Day Year
, P.O. Bares that the designed by the detached	<u> </u>	ns contributing to death but not res	ulting in the ur	nderlying cause giv	ven in Part I.			e to the cause of death? Probably 4 Unknown
aw requi						24a. Was a autops perform	sy prior med? deati	
Vital Rec ysician: The l his certificate l director, page	examiner?	Hospital: 1 Inpatient 2 E	R/Outpatient	10	of Death (Check		Residence 6 🗸 O	ther: Scene
ion of Virtending Physicath. tor: After this the funeral direction: To		28a. Date of Injury (Month, Day,Year)	28b. Time of In	ijury 28c. Injury		28d. Describe h	ow injury occurred	
Division o Spital or Attending sours after death. neral Director: Aft filled in by the fune	3 Suicide 6 X Could determ	not be 28e. Place of Injury - At hom	ne, farm, stree	t, factory, office bu	ilding, etc.	28f. Location (S or Town, Si Baltimo	street and Number of tate) 1102 Dr re, MD	Rural Route Number, City uid Hill Ave
Divisior To the Hospital or Attend within 24 hours after death To the Finneral Director: completely filled in by the		rsician: To the best of my knowledge iner: On the basis of examination and and manner stated.	e, death occurr d/or investigati	red at the time, date on, In my opinion,	e and place, an death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due t	stated. o the cause(s)
2	29b. Signature and title of certifier	1 7 / TOWN	4	29c. License O.C.M	001	ЛЕ	29d. Date signed September 23	
1 stray	30. Name and address of person v Theodore M. King, Jr.,	who completed cause of death (Item 2 MD. Assistant Medical Ex		111 Penn Stre	eet, Baltimo	re, MD 21201		
Stat Registra		32. Registrar's Signature	Acres M.	8				
DHMH 17 Rev 1/2001		A	ÖRIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O9 **Physician** 05 PM OWard 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Randallstown 5401 140 10 Old Court Rd easons 7. Age (In yrs. last birthday) 78 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number **Funeral** Hours Months Days 018910044/1930 1 X M 2 □ F MD 214-26-3604 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Extra in the found to any injury or other traumatic event, I'm Medical Extra in the found. MD Baltimore Randallstown Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 U.S.A. 3515 Cornstream Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Morton Alwina Espie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Fabella / Cousin 4002 Overlea Ave. Baltimore, MD 21206 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X remation 3 ☐ Removal from State Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signifure of Juneral Service Licensee of Cota 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Find-stage Albheimers Dementin **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to know death cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed ending physician and use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) ent has pile Hospital: 1 □ Yes _ 2 □ N/6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9126/08 apuneMD D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200, Reisterstown 25 Main Sti Jsuite ,MD N.S. Kajupavse 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year SEPT 25 2008 EDWARD V. MUSE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death BALTI MORE If Under 1 Year | If Under 24 Hrs. N/A HOSPITAL AGNES 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Sex †EM 2□ F Months Days Hours Min. 66 MARYLAND 11-25-1941 214-40-8579 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 XYes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3813 TAWONDA AVE. 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSES AIDE **HEALHCARE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS MUSE RUTH BOWLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACEY MUSE (DAUGHTER) 5030 PEMBRIDGE 2nd FLOOR BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 Cren 4 Donation 5 Other (Specify) METRO CREMATORY 9-29-2008 BALTIMORE, MARYLAND uneral Se vice Licer HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. *****eJONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS disease or condition resulting in death) DILATED CARDIOMYOPATHY Due to (or as a consequence of): ACUTE CHOLECYSTITIS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off 5DAYS PNEUM ON/A resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner Examiner

Physician

/Medical

Director

Funeral

Completed by

Be 2

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.

3altimore, Maryland 21215-0036

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Certification: To

Medical

Jedical

The law requires that the death certificate be executed P.O. Box 68760. Vital Records, ARD アマッ the Hospital or Attending Physician: Division となるの within 24 hours after death. To the Funeral Director: A

		1 Tes 2 No 3 Probably 4 Unknown				
		24a. Was an autopsy performed? 1				
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)				
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	3d. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 ★Certifying Ph (Check only one) 2 ★ Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)				

29c. License number

29d. Date signed (Month, Day, Year)

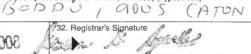
SEPT 25 2008

AVENUE, BALTIMORE, MD 21229

State Registrar

VEERAJA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



eles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For State	State of Marylar	•	artment of F r <i>tificate of I</i>		nd Ment		ene . No. 2 11 11	g 2	1 1. 1. 1
		Registrar 1. Decedent's Name (First, Middle, Las			- Inouto or	Dodin		ate of Death	200	3. Tim	e of Death
Physici /Medi		Florence M. Ogl	e				Sept	ember	26, 200	8 9:4	40 р ^м
Examir	ier	4a. Facility Name (If not institution, give Williamsport Nu			4b. City, Town, o		Death	-	4c. County of Death		
· 		5. Social Security Number 6. Se		last hirthday)	William If Under 1 Year	-	4 Hrs. I a Da	ate of Birth	Washington		
Funeral Director			Эм ЖЭг 89	Yrs.	Months Days		Min. (M	ate of Birth Jonth, Day, Y e 25,	Birth Day, Year) 9. Birthplace (State or Foreig Country) 25, 1919 Maryland		
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h the	Director	10e. Street and Number			10f. Zip Code			100	. Citizen of What	Country?	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show with injury or other traumatic event, the Medical Eventral Traumatic event, the Medical Eventral Traumatic event.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ሺ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates:		Was Decedent of H fYes, specify Cuba 1 □Yes 2ሺ No	lispanic Originan, Mexican, I Specify:	n? (Specify Y Puerto Rican,	es or No- etc.)		merican Indiar hite, etc. white	١,
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Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the deat ne cause on each line.	h. Do not ent		ng, such as ca	ardiac or resp	iratory arres	t,	Approxi Interval	
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
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uted	Examiner	Sequentially list conditions, if any, leading to immodrate cause. Enter Underlying Cause (Disease or injury that initiated events		,							
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Attending Physician: The law requires that the death certifored of the death certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year		
s that	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	2	3e. Did toba	cco use contribut	e to the cause	of death?
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hysie this c	၉	1 ☐ Yes 2√7 No	Hospital: 1 ☐ Inpatient 2 ☐			4 D Nurs	ing Home 5	Residen	ce 6 □Other (5	Specify)	
ding F h. After funera	Certification:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl	ryat k? Yes 2 ∐ No		escribe how	injury occurred		
Atten r deat ector	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	l ome, farm, str				cation (Stre	et and Number o	r Rural Route I	Number,
alor safter	Serti	4 ☐ Homicide determined	building, etc. (Special	fy)			C	ity or Town,	State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	siclan: To the best of my knowing: On the basis of examination and manner stated.	owledge, deatl ation and/or in	n occurred at the til vestigation, in my o	me, date and opinion, death	place, and di	ue to the cau	ise(s) and manne e and place, and	r as stated. due to the cau	se(s)
To the com	Ž	29b. Signature and title of certifier	1		29c. Licens	e number		290	. Date signed (M	onth, Day, Yea	ır)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 . Decedent's Name (First, Middle, Last) 2. Date of Death September 27 **Physician** 2008 В. Mildred Overcash 10:00am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17 C Warren Lodge Court Baltimore Cockeysville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M XXF Director 242-20-7170 85 Sept. 11, ŃC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 17 C Warren Lodge Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify. Specify. δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 years Finisher- Sander Furniture Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Beam 2 Sendia Murph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Fine (son) 17 C Warren Lodge Court Cockeysville, MD 21030 20a. Method of Disposition

↑ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Evergreen Mem. Gardens 9-30-2008 Finksburg, MD 4 Donation 5 Dother (Specify) 21. Signature 22. Name and Address of Facility of Funeral Service Licensee 11824 Reisterstown Road J→ Wayne Osterling ELINE FUNERAL HOME Reisterstown, MD 21136 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Parti. Enter the shock, or heart fa Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and I-tran physician a Due to (or as a consequ Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page certificate 1 ☐ Yes 2 No 1□ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tes 은 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this c 5 Residence 6 □Other (Specify) 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Hospital or Attending Natural Injury 1 □ Yes 2 □ No death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

P.O. Records, Division or Vital within 24 hours after death

To the Funeral Director:
completely filled in by the To the

State

DHMH 17 Rev 1/2001

Registrar

30. Name and ddress

oseph

31. Date filed Month, Day, Year)

32. Registrar's Signature

1205

f person who completed cause of death (Item 23a) (Type, Print)

Road #30 Lutherville, MD 21093

Amend #1 per MD g884 10.23.08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Patricia Irene Piccioni 2. Date of Death 3. Time of Death Month Day Year Physician 715 PM PICCIONE SEPTEMBER 30 2008 PATRICIA TRENE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CALUART 13336 LUSBY CONCHO COURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**▼**F Days Yrs 219-56-0695 01/05/1949 WASHISLTON SC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD CALVERT LUSBY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2065 USA CONCHO 2226 COURT Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 M Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARE HEALTH AID permit. Pages 1 and 2 should be filed beatment of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BETTY ENGLAND JUSEPH HOWARD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2065 LUSBY MD RUBLAT BROWN 13939 CONCHO CT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) ANATOMY GIFTS RELISTRY 10/2/2008 HANDVIER MARTLAND 22. Name and Address of Facility
ANATOMY WIFTS THUSTER 21. Signature of Funeral Service Licensee STEP, HANDUCK MA 31076 75722 CONNELLEY DR. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months Malignant melanoma /Medical Due to (or as a pansequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine y physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 □ Yes certificate 1☐ Yes 2 No 2□ No Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home SA Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident nin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Prince Frederick, MD 20678 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
110 HOSpital Road, Svite 212 110 Hospital

State Registrar 31. Date filed (Month, Day, Year)

02

2246

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 🖰 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day Year BLANCHE 4)ALLANE 0550 M Septemb, 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death City Examiner to pita NIA 3025 1mone If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months 1 ☐ M 2 🕱 F 269-20-2630 Director MICHIGAN AUG. 27, 1 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exercitor must be notified at 10d. Inside City Limits Director BALTIMORE MARYLAND 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HITTIER Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) i o 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No ģ Specify: Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than "other traumatic event, Inc Max. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR SOCIAL SECURITY FLOWING YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALLACE PHELIX WHETZE! JUSEPHINE ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6920 S. CARLINIDA AVE, COLUMBIA, MD 21046 RAYMOND LUCAS (NEPHEW) If item 27 or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ■ Burial 2 Cremation 3 □ Removal from State Department or Important: If any injury or ARBUTUS MEM, PARK 109-12-2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 22. Name and Address of Facility

505 EPH H. BROWN JR. FUNERAL HOME
2140 N. FULTONAVE, BALTIMORE, MD 21217 cehich N.le Illiamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Awte hyschyth mia rardiac 2 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immedial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be execute and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 morths? 23d Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) Ö 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pertension Completed 2 No 3 Probably 4 Unknown 1 □ Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 1 No of Vital 1 □ Yes 2 2 10 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1∐ Yes Certification: To 1 Inpatient 2.☐ ER/Outpatient 3 ☐ DOA After this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Division 5 ☐ Pending investigation 1 atural 2 Accident 1 ☐ Yes 2 □ No Director: Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral I Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated. (Check only the within ? 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DEA BC9914795 MD September 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore maybered 21212 400 South caton Avenue Meghan Checkles 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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artme ortan Injur	ŀ	4 Donation 5 Other (Specify) Atlantic Crematory 9/30/2008 Glen Burnie, Maryland 21. Signature of Funeral Service Liversee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc.													
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/Medical Examiner		resulting in death)	6	Due to (or a											7
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ured insit	Examiner	Cause (Disease or	injury	Buc to (or a	o a consequ	a consequence of):									
oe executed cian and ourial-transit	Еха	that initiated events resulting in death) L		C. Due to (or a	s a consequ										
physicia physicia the bur	ical			d											
earn ceruircate b attending physic for use as the b	Physician/Medical	IF FEMALE:													
atn ce ttend or use	ian/	23b. Was decedent		23c. If yes, outcom 1 ☐ Live birth	2 Fetal	death 3	□Ectopic p		у					ate of deli onth	ivery Day Year
the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□Pregnant : 9□Unknown	at time of de	eath 5	Other (sp	ecity) _							
inar i led by detar		Part II. Other signif	ficant conditions	contributing to death	but not resu	ılting in the	underlying o	ause giv	en in Part	l.	23e. Did	tobacco	use con	tribute to	the cause of death?
w requires that the dibben signed by the should be detached	ed by										1 🗆] Yes	2 N o	3□ Pr	obabiy 4 ∐Unknown
aw re is bee 2 sho	Completed										24a. Wa		24b.		topsy findings available
ate ha	mo										per 1 Yes	opsy formed? 2 3		death?	completion of cause of 2 ☐ No
ertifica ctor,	Be C	25. Was case refer examiner?	red to medical							e of Deat	h (Check only				
this c	ဥ	1 ☐ Yes 2		Hospital: 1 ☐ Inpat			ent 3 DC		4 L N		me 5 Pes				cify)
uing rny n. After this funeral d	ion:	27. Manner of Deat 1 ☐ Natural	5 ☐ Pending investigat	28a. Date of In (Month, D		28b. Time Injury	M Z	28c. Inju Woi	ryat rk? ∣Yes 2.⊟		28d. Describe	now inj	jury occu	rred	
deatl deatl sctor:	fical	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not determine	be 28e. Place of ir							28f. Location	(Street a	a <i>nd Num</i>	ber or Ru	ıral Route Number,
al or y s after il Dire	Certification:	4 ☐ Homicide	determine	building, e	etc. (Specify	/)					City or To	own, Sta	ite)		,
nospir hours unera		29a, Certifier (Check only	1 Certifying	Physician: To the bes aminer: On the basis	t of my know	wledge, dea	ath occurred	at the ti	me, date a	nd place,	and due to the	e cause	(s) and m	nanner as	s stated.
To the notice the second secon	Medical	one)		and manner s	tated.				se number		Tod at the time				
- M F		29b. Signature and	0/1.	-				-	_	10		-0	,		h, Day, Year)
1	}	30 Name and add	rass of nareon wh	o completed cause of	death (Itom	23a) (Tuna	Print)		J /	1 -		26	PT	- 1	1,200P
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ken Will, mm 112-N. Rolling Rd Brehm 5 2127 8 31. Date filed (Month, Day, Year) CC 1 0 2 2008 32. Tegistrar's Signature													
Sta	te	31. Date filed (Mon	oth, Day, Year)	2000 32. Regis	trar's Signa	ture	A	_							
Registr	ar		JUI UZ	2000	But s	J. 16	20462	ē							

			1- For State of Maryland / Dep	eartment of Health and Nertificate of Death	/lental Hygiene Reg. No.	71111X 3 11.1.U
35	Physici		Decedent's Name (First, Middle, Last) FRANCES PATRICIA PUTSCHE		2. Date of Death September 28,	3. Time of Death 9:00A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 506 Limerick Circle	4b. City, Town, or Location of Death Timonium		County of Death Baltimore
	Funeral Director	(Z,	5. Social Security Number 215-05-8568 Usual Residence of Decedent 6. Sex 1 M 2 W 7. Age (In yrs. last birthday 90 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day Year) April 12,1918	9. Birthplace (State or Foreign Maryland
	ryland how at		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	the Ma 28a-fs otified	ecto	Maryland Baltimore Timonium 10e. Street and Number	10f. Zip Code	10g Citi	1 ☐ Yes 2 No izen of What Country?
	th with	al Dir	506 Limerick Circle	21093	109. 011	USA
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 XXIII Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-00	72 hou natura lical E	eted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Ki	ind of Business/Industry
121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired) Cutive Assistant		nking
Baltimore, Maryland 21215-0036		To Be Completed by	17. Father's Name (First, Middle, Last) Bernard Moran	18. Mother's Nam	e (First, Middle, Maiden elia Sanner	
Mary				ing Address (Street and Number or Ru. Riverview Road Baltimor		
ore,			AM Dulial 2 (Liciellatiuli 3 Linelloval Iloui State)	ematory or other place)		ocation - City or Town, State
Ħ Hi	artmen artmen ortant: Injury		4 □ Donation 5 □ Other (Specify) / New Cathed	ral Cemetery October 22. Name and Address of Facility Mit		timore, Maryland
Ba	Dep Imp any onc		XIMMOX (HOLDON NOMINKA)	6500 York Ro	oad Baltimore.	Maryland 21212
8760, %	Physician //Medical Examiner the primal-transit the primal-transit	lical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. List of to shift Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death I WCCAC	
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 544 hours after cleath. On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that en signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
Division or Vital Records,	ding Physician: The law requir n. After this certificate has been si funeral director, page 2 should	Completed			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
<u>=</u>	/slcian s certifi lirector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor:	h (Check only one) ome 5 Residence	G TOther (Create)
n or	ng Phy offer this		27. Manner of Death 1 Manner of Death 1 Manural 5 Pending (Month, Day Year) Injury 1 Injury 1 Pending (Month, Day Year) Injury		28d. Describe how injur	
Divisio	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No treet, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date and	d place, and due to the cause(s)
	To t To 1	Σ	29b. Signature and title of certifier wallace my	29c. License number	29d. Dat	te signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type	9>(136	100	HEMSELLT, 2008
_			BRIAN C-WALLACE MD, 9	005 KILBRIDE	S RD. BA	LTIMORE MD 21236
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 2 2008 32. Begistrar's Signature	berte		te signed (Month, Day, Year) PTEMSEL 29, 2008 LTTMORE, MD 21236

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Registrar DHMH 17 Rev 1/2001

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ANUSHA IYER, ST AGNES HOSPITAL 900 S CATON AVE, BALTIMORE, MO - 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

31. Date filed (Month, Pay-Year)

P 2 2 0 0 4 SEPTEMBER 27, 2008

				1 - For State amend 27 p	State of Ma er DR. g8	aryland . 84 10	/ Depa	irtment of l	Health and M Death		giene 20	08	31451		
				Decedent's Name (First, Middle, Las	2. Date of Death 3. Time of De										
		Physici /Medic		Baby Robinson-Mo						09 13 200			2230 PM		
	1	Examir		4a. Fecility Name (If not institution, give	street and number)	000	101	4b. City, Town,	or Location of Death		4c. County	of Deeth	A		
		- k		5. Social Security Number 6. Se	HOSPITUL Exunk 7. Ag	e (In yrs. last	hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	DMII	9. Birtho	place (State or Foreign		
		Funeral Director		infant	M 2 F	e (III yis. iasi	Yrs.	Months Days		8. Date of Birth (Month, Day Sept 1:		Cour	ntry)		
				Usual Residence of Decedent		T				, , , , , , , , , , , , , , , , , , , ,					
		ahow	_	Tod. State									10d. Inside City Limits 1 Yes 2 No		
		oth with the M 23a or 28a-f	ecto								10g. Citizen of V	Vhat Cour			
			ă	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co									,		
			era	6636 Eber1in Drive 21215 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A. Black, W. Black, W.							e - Americ k, White,				
	9	after des	Ē	1 X Never Mamied 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ ↑ If Yes, Give	No	1	r Yes, specify Cut I □ Yes 21√2 No		Specify:			black		
_	0036	ural'.	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:								DIACK			
>	ည်	n 72 h	lete	15. Decedent's Ed (Specify only highest gra-		1	l6a. Deced (Give life. l	lent's Usual Occu kind of work done DO NOT use retire	pation during most of work ed)	ing	16b. Kind of Bu	siness/in	dustry		
ب	12	withi iene. r than	gmo	Elementary/Secondary (0-12) infant	Cottege (1-4or 5	5+)		infant			infa	nt			
5	p	permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item 900ce.	Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)		'		unk	18. Mother's Nam	e (First, Middle,	(First, Middle, Maiden Sumame)				
2	/lar		To B			a Robinson-Motley									
0	Man			19a. Informant's Name/Relationship (7) Franklin Square					square D				21237		
S	re,			20a. Method of Disposition				sition (Name of natory or other pla		Date	20c. Location -	City or To	own, State		
Robinson MOA	Baltimore, Maryland 2121			1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☑ Other (Specify) in state			*							
Z	Bai	Depar Impor any in		21. Signatur Funeral Sande Licen	We Dir	ector		ate Anat 1timore,	ess of Facility Comy Board MD 2120		Baltimo	ore S	Street		
•	E	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and in positive that the funeral director, page 2 should be detached for use as the burial-transit.		23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of): ECCTIVE ADOLLTO Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d.											
			dical Examiner												
			by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year									
				Part II. Other significant conditions of	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
			Be Completed							24a. Was autop perfor	sy rmed2	Were auto prior to co death?	opsy findings available impletion of cause of		
	/ita			25. Was case referred to medical examiner?					26. Place of Deat	h (Check only o	ne)				
	→		2	1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No								(y)			
1	Division o		Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Accident investigation 28d. Describe how injury occurred 1 Yes 2 No											
4 3				3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)									al Route Number,		
*		ne Hospital	edical C	29a. Certifier (Check only one) to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date signed (Month, Day, Year)				
	•			> William & 1911	M MO			KES	0000		9/13/2008				
-				30. Name and address of person who	completed cause of d	leath (Item 23	3a) (Type,	Print)	MAN DIS	Dallin	2000 1	n 0	1222		
		* *		31. Date filed (Month, Day, Year)	UKU 9(ar's Signature	ran	cin all	MIT Ur.	Baltin	WIT, M	02	リムグナ		
		Sta Registi		OCT 0 2	2008	Esperature d	H.	parte							

		1 - For State Registrar		artment of Health and tificate of Death	Reg. No	0000 011 0					
Physic /Med		1. Decedent's Name (First, Middle, Last) NORMA		ZEYNARD 4b. City. Town, or Location of Death	SEPTEMBER	3. Time of Death 25 2008 08:20 M c. County of Death					
Exam		4a. Facility Name (It not institution, give street and The Johns Hopkins Hospital 5. Social Security Number 6. Sex		Baltimore City If Under 1 Year If Under 24 Hrs	8 Date of Birth	N/A					
Funera Director		284-24-6696 Usual Residence of Decedent		Months Days Hours Min.	(Month, Day, Year) 1-8-1930	PA PA					
e Maryland 3a-f show ified at	Director	10a. State 10b. County Baltimore	10c. City, Town or Lo	Halethorpe		10d. Inside City Limits 1 ☐ Yes 2 ☑ No					
th with the 23a or 28 ust be not	ral Dire	978 Circle Drive		10f, Zip-Code 21227		itizen of What Country? USA					
JSO Irs after dee	by Funeral	1 Never Married 2 Married 1 If Ye	Yes 2 X No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes Mary No Specify:	pecity Yes of No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Caucasian					
BAITIMOTE, IMATYIANG Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or Items 23a or 28a-f show any highy or other traumatic event, the Medical Examiner must be notified at any one.	Completed		eted) (Give life. I	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)		Kind of Business/Industry					
and < 1 be filed w ntal Hygier ed other the event, the	Be Cor	12 17. Father's Name (First, Middle, Last) Joseph Stofko			me (First, Middle, Maide ra Ponta						
Maryland id 2 should be file th and Mental Hy 27 is marked oth	2	19a. Informant's Name/Relationship (Type. Print Cynthia Anne Foy	, i	ng Address (Street and Number or A		Number, City or Town, State, Zip Code)					
SAITIMOTE, oermit. Pages 1 an Department of Heal Important: If item 2 any Injury or other	1	2. ethod of Disposition 1 Burial 2 Cremation 3 Removal 4 panation 5 Other (Specify)	from State 20b. Place of Dispo	osition (Name of matory or other place)	Date 20c. I	Location - City or Town, State					
Dani. permit. Departm Importa any inju		21. Signature of Euneral Service Livensee	13	2. Name and Address of Facility Am 328 Sulphur Sprin	g Rd., Arbu	itus, MD <u>21227</u>					
Physician		Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. HYPOTENSION Approximate Interval active mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Cause (Final disease or condition 5 DAYS									
/Medical Examiner		Due to (or as a consequence of): NELROTIZING MYOSITIS									
icate be executed physician and sthe burial-transit	Examiner										
os/ou, artificate be ex ng physician e as the buria	/Medical	JF FEMALE:	es, outcome of pregnancy			Old Date of delivery					
Hecords, F.O. BOX of le law requires that the death certif has been signed by the attending ge 2 should be detached for use a	Physician/M	in the past 12 months?	Live birth 2 Fetal death 3	Ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
rds, FO.	5	Part II. Other significant conditions contribution	o use contribute to the cause of death? 2XNo 3 □ Probably 4 □ Unknown								
I HECOTICS, F.O. BOX of The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed			24a. Was an autopsy performed?	autopsy prior to completion of cause of death?						
OT VITA Physician: this certificatal director,	To Be		1 Inpatient 2 ER/Outpatier Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing I	ath (Check only one) Home 5 ☐ Residence 28d. Describe how in						
or Attending or Attending after death. Director; After tin by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of injury - At home, farm, stribullding, etc. (Specify)	t and Number or Rural Route Number, ate)							
To the Hospital or Attend within 24 hours after deat To the Funeral Director: , completely filled in by the	Medical Ce	29a. Certifier (check only one) (check only one) (check only one) (check only one) (check only one)									
To the within To the comple	Med	29b. Signature and title of certifier		29c. License number CTOR RES - 000		Date signed (Month, Day, Year) TEM BER 25, 2008					
		30. Name and address of person who complete IBIRONKE ODUYERD, Jo H 31. Date filed (Month, Day, Year)	ed cause of death (Item 23a) (Type	, Print)		St, Baltimore, MD, 2128					
Regi:	State strar	OCT 0.2. 2008	ownegistral s digridule	A.60							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18:33pm September 29 2008 4c. County of Death /Medical Robert Andrew Reiter, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. Agnes Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Min Days Hours 1 X M 2 □ F 215-40-2890 Yrs Director 69 Dec. 6, 1938 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □Yes 2 NO Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 715 Maiden Choice Lane CR506 21228 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1961-63 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Life Insurance Salesman Life Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Andrew Reiter, Sr. Pauline LeClaire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Reiter, III Son 51 Jacobs Ladder Court; Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 10/4/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tremiz Physician encephalopeth weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to him class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a nonsequence of) law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1ДSYes 2□ No 2 No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Melista Burkmo Pathologi3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stagnes Hospital, 900 Caton Avenue

State Registrar Burk

02

2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 02 PM ROBINSON 2008 ASSIE 29 September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown BOLTIMORE HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 X F 5-22-1930 SOUTH CAROLINA Director 212-26-0155 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Mudal Examination and once. 1 XYes 2 ☐ No BALTIMORE Director MD. N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 USA 446 ROUNDVIEW RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify BLACK Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WESTINGHOUSE -0-WELDER -10-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUISE OWENS JOHN GILBERT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 446 ROUNDVIEW RD. BALTIMORE, MARYLAND 21225 PRESTON BRYAN (GRANDSON) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposi 1 ⊠ Burial 2 □ 4 □ Donation 6 3 Removal from State remation MEADOWRIDGE CEMETERY 10-3-2008 ELKRIDGE. MARYLAND Other (Specify) D. HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par 1. E. fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, y heart failure. List only one cause on each line. Congestive Heart Failure Onset and Death Immediate dause (Final disease accondition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) ned by the a detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 - No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident l or Attend after death Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year)
September, 29, 2008 29b. Signature and title of certifier 5401 Old Court Road, Randallstown, MD 21133. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 Month Year **Physician** 2008 0810 Jusan September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Maryland 214-72-5531 51 **Director** Feb 7.1957 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show or 28a-f sho 1√ Yes 2 No Director Baltimore City Md. Apt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code r items 23a or Iner must be n ö death with 21223 1010 West Baltimore Street 201 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and 2 should be filed within 72 hours after teatth and Mental Hygiene. m 27 is marked other than "natural", or Ite Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: ۵ White 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bartender Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Giardina Gilbert Barrett 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 19a. Informant's Name/Relationship (Type. Print) Husband William Carroll Clark 1010 West Baltimore Street Baltimore, Md. Item 27 20b. Place of Disposition (Name of cometery, crematory or other place)
Oak Lawn Cemetery 10-3-2008 Baltimore, Maryland 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once: 1 Burial 2 Cremation 3 Removal from State 0ak 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1201 Dundalk Avenue Baltimore, Md. 21222 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hult: Due to (or as a consequence of) /Medical Examiner tailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): triculpid valve The law requires that the death certificate be executed repail g physician and as the burial-trans Due to (or as a consequence of): resulting in death) Last P.O. Box 68760, Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Division of Vital Records, 2 4 Unknown 2 No 3 Probably 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1X Inpatient 2 ER/Outpatient 3 🗌 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation Injury al or Attendings after death. 1 ☐ Yes 2 ☐ No Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital of within 24 hours at To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00067863 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra 600 North Wolfe St, Baltimore, MD, 21287 rerhard 31. Date filed (Month, Day, Year) rar's Signature State OCT 0 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death sept. 26, 2008 Year **Physician** 0910 Lona F. Seymour /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Cheaspeake Hospital Belair 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 18, 1936 Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 234-58-0612 1 □ M 2 □ M 71 WVA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ith Modical Expiritme tourst by rediffed. Director Baltimore Essex 1 ☐ Yes XX No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 415 Beck Street 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home 9th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gordon McCumber Edith Grove 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Beck Street Baltimore MD 21221 /husbahd George Seymour Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 10/01/08 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death severe Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit the attending physician and P.O. Box 68760, 12 Due to (or as a consequence of) Physician/Medical nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Enterologial bacteremia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Musti-organ failure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an autopsy performed? yes 2 2 No DVT certificate 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury accurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 1 Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 26,2008 Chain

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26,2008

September

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Lona

Seymour

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Kharal

500 upper chesapeake Dr. Bel Air, MD 21014

			For State Registrar		State of M	arylan		partment <i>ertificate</i>			Mental F	lygier Reg. N	-2009	3	1457	
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	/Medic							Stuckey 0								
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	Funeral Director		5. Social Security N		Sex 7. Ag 1 🔀 M 2 🗆 F	e (In yrs. la	as <i>t birthda</i> Yrs	Months	Days Days	If Under 24 Hrs Hours Min	. (Month,	Day, Yea		thplace (Sta ountry)	ate or Foreign	
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Ratimore Meryland 21215,0036	be filed within 72 hours atter death with the Maryland the Hyglene. I have a compared to the transmission of the transmission	by Funeral	11. Marital Status 1 ☑ Never Marr 3 ☐ Widowed	rled 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2. If Yes, Give Year or Dates:		6. 1	3. Was Decede If Yes, speci 1 □ Yes 2		panic Origin? (S , Mexican, Puer Specify:	Specify Yes or to Rican, etc.)	No-	14. Race - Ame Black, Whit Specify:			
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<u> </u>	permit. Pages 1 Department of the Important: If ite any injury or ot once.		21. Si rratul of Fu	uneral Service Lice	nsee K	ete		22. Name and March 4300 W	F/H	West	, Balt	imo	re, Md	212	15	
			23a. Part 1. Enter t shock, or hea Immediate Cause	art ure. List only	nplications that cause one cause on each li	ne.	Do not	enter the mode	of dying,	, such as cardia	c or respiratory	arrest,		 Onset a 	Between nd Death	
3	Physician /Medical		disease or condition resulting in death)	on	a. LUNG Due to (or as			Rw	th	Meta	stas	es	i i	6 M	uffis	
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9.2 Box 6	• ਵਾਲਾਂ		IF FEMALE: 23b. Was decedent	t progrant	23c. If yes, outcome	If yes, outcome of pregnancy						23d. Date of			delivery	
C	that the death	Physician/N	in the past 12 1 Yes 2 Unknown	months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								Day	Year		
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vey, of Vital	Physician; this certific		25. Was case referrexaminer? 1 ☐ Yes 2 ▼		Hospital:	ent 2∏E	ER/Outpat	tient 3 □ DOA	Othor	26. Place of De			Other (Sno	oit HOS	PICS	
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Stuc	Attending ir death. ector: Afte by the fune	ficati	2 ☐ Accident 3 ☐ Suicide	investigatio 6	e 200 Place of Init	ırv - At bor	ne. farm.	M street factory		s 2 No	28f Location	(Streat	and Number or Pi	ural Pauta I	dumber	
, io	Hospital or Attence 24 hours after death Funeral Director: etely filled in by the	Certification:	28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									varnoer,				
	To the Hospital within 24 hours a Volume and To the Funeral I completely filled	ledical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.										e(s) and manner and due	s stated. e to the cau	se(s)	
	or Neiti	Σ	29b. Signature and	title of certifier	-Rfa	reli	cei	S 2992	D 3		-3		Pate signed (Mont	h, Day, Yea Joc) &	
	2	-	30. Name and addr	ress of person who	completed cause of d	eath (Item	23a) (Typ	e, Print)	Jsan	+564 town	Blud	/Ba	ecto Mi	7 31	204	
	Stat Registra		31. Date filed (Monito OCT	th, Day, Year) 0 2 2008	32. Registry	r's Signatu	Jre Jean	£ 1							Ţ.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year James SEPT. 28, 2008 3:30 A M R. /Medical Svehla 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 X M 2 □ F Maryland Director 215-12-8973 April 10,1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a.4 other any injury or other traumatic event, the Medical Experiments. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 TYes 2 X No Baltimore Catonsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 1721 Edmondson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Date WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No ۾ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Corps of Engineers Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary James Svehla Stranskv ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Svehla / Nephew 1721 Edmondson Ave./ Baltimore, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 10/1/08 Overlea, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licence William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Wound disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) ☐Yes 2☐No signed by the 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. the of certifier 29b. Signature and 29d. Date signed (Month. Dav. Year)

10 11

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

CLINE,

CASPER

300 W. 94L St.
32. Registrar's Signature

30. Name and address Merson who completed cause of death (Item 23a) (Type, Print)

MD

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTENBER DAY 7. 2008 8:30P Morris Lemual Taylor /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Center Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 86 Months Days Hours Min. 1XM 2□F Director 214-12-8278 July 30 1922 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" -- " any injury or other traumatic ever." 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Genesis Multi Care Ctr., 7700 York Rd. 21204 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates 42 − 45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: by 3 ☑ Widowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Liquor 12 Salesman n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Lemual Taylor, Sr. ပ Edith Webb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert R. Taylor/son 17 Melanie Ct., Balto., MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Atlantic Crematory 9/20/08 Glen Burnie, MD 21. Signature Jame al Sev 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. IO W. Padonia Rd., Timonium, MD 21093, Inc. Michae 23a. Part1. Enter the disease, shock, or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final HYPOTENSION Onset and Death **Physician** disease or condition resulting in death) /Medical INFECTION Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit SEPTIC SHOCK and Due to (or as a consequence of): ACUTE RENAL FAILURE physician as attending properties IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) the detached 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 No page 2 s autopsy perfori certificate 2**1 N**o 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending

P.O. Box 68760. Division or Vital Records, funeral director, After t To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. the

filled in by

completely

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Nonth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOKOTAKIS, M. D.

7601 OSLER DRIVE

D56030

1 Yes 2 No

TOWSON, MARYLAND 21204

Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year) OCT 0 2 2008

investigation

6 Could not be determined

3 ☐ Suicide

4 Homicide

EMANUEL J.



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 09 28 2008 William Clarence Vinson 8:53a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Sinai Hospital If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days M 2 ☐ F **7**8 Director 06 08 MD 215-22-6110 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at</u> 1 X Yes 2 □ No Director MD NA Baltimore 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 4023 Bareva Road 21215 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fifty Regiment Elementary/Secondary (0-12) College (1-4or 5+) Armory lyr Engineer 12th grade Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christine Stallings 2 Clarence Vinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. 4023 Bareva Road, Baltimore, Md 21215 <u>Carmeta M. Vinson-Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 10/3/08 Owings Mills, Md 22. Name and Address of Facility
March F/H West uture di Funeral Service Licensee donal 21215 4300 Wabash Ave, Baltimore, 23a. Parl/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ch line. CVD diate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 or Attending Physiclan: The performed death? 1 □ Yes 2 No 219110 1∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To After this 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Medical 29a, Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year) 541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wordham woods

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- StatAmend 19b, perFH G884 10/2/08 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl **Physician** 09-28-2008 AT.MA SUE WILLIAMS 7:57 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CASEY HOUSE MONTGOMERY CO. ROCKVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 03-18-1937 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 X F 71 VIRGINIA Director 375-40-5454 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f shov Director DC WASHINGTON 1 Yes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23a or items. 900 VARNEY STREET, SE #006 20032 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Completed by Specify Specify: BLACK 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) HOMEMAKER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIE MITCHELL OLLIE Μ. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2729 King St. #149B Alexander, VA 20876 19a. Informant's Name/Relationship (Type. Print) JAMES WILLIAMS - HUSBAND or other 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 0-06-2008 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Ceme. permit. Page Department (Important: If any Injury or once. Brentwood, MD 4 Donation 5 DOther (Specify) 21. Strinature of Funeral Service Licenses 22. Name and Address of FacilityRONALD TAYLOR II FUNERAL HM travolal (10583 MIDDLEPORT LANE, WHITE PLAINS, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aLiver Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

o. ٦. Records. of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, al or Attending F Division Hospital

To the I within 2

State Registrar

ca

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Muncaster Mill

and manner stated.

6001 Rockville,MD 20855

31. Date filed (Month, Day, Year) 32. Registrar's Signature

revere

2 ws

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AL Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

10-01-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** DANIEL ARMIGER WEBSTER 55075MS-57.29 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANJUE ARUNDEL ANNAPUS der 1 Year | If Under 24 Hrs. ARVID DEL MEDICAL CENTER 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 □ F DELAWARE 216-74-459 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner rust be notified at 1 ☐ Yes 2 No MIJ Director ARWIDEL ANNE ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 STREET by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 □ No 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married 1 □Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 Divorced and Mental Hygiene. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ELECTRICIAN 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If iten 27 is marked ofth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be JOSEPH WEBSTER **L015** WISE ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MAPL SEAFORD DR. JAMES WEBSTER /BROTHES? Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HANDUKR, MARYLAUL 1000 \$ 10 MESTER STAIN 4NOTON 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21076 21. Signature of Juneral Service Licensee an shicean 13 7522 CONNELLEY DRIVE, STE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial /Medical Due to (or as a consequence of): Examiner atheroscleratic Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician Physician/Medical the as for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown 9 🗌 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown rena 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Vital Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division of this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 □Yes 2 □ No 24 hours after death. ▶ Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number 58510 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olexo 31. Date filed (Month, Day, Dh 32. Registrar's Signature State OCT 0 2 2008 Registrar Miles Contract

Examiner signed by the attending physician and d be detached for use as the burial-transi has After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show

'natural", or

Department of Important: If It any injury or conce.

Physician

/Medical

Director

Funeral

2

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

8:30

SEPTEMBER

/Medical

21. Signature of Sunsair San 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No 27. Manner of Death Certification; 1 X Natural 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical stated and manner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DR. ERNESTINE WRIGHT

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. 32 Registrar's Signature

TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death sept. **Physician** 25^{Day}2008^{Year} Clyde W. Woodard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ivy Hall Nursing Home Middle River If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 29, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 238-01-8321 1 **m**M 2 □ F 88 NC **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Exemitant institut by notified at MD Baltimore Middle River Director 1 ∐Yes 2√∑ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 7 Raspberry Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ If Yes. Give Specify Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self-employed Food Service 12th marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi Health and Mental H Be Tally Monroe Woodard Lily Guinn Woodard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .0 of Health a item 27 is Linda Gail Hart /daughter 7 Raspberry Court Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State o Important; If it any injury or c 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Bayview Crematory 9/27/08 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Sign sture of Funeral Servi 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 23a. Parvi. Enter the disease, or complishock, or heart failure. List only on ons that caused the death. Do not enter the mode of dying, such as cardiac or respirat ause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🕅 Yes 2 🗌 No 3 🗌 Probably 4 🗍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed page ; certificate of Vital 2 🗆 No 1 ☐ Yes 2 No 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

leral Director; A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type O, 10102 31. Date filed (Month, Day, Year) 32. Registrar's Signature 02 2008 Registrar

Dennis Brian Woolford State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year September 26, 2008 0729 hrs **Medical Examiner** Dennis Brian Woolford 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** 13538 Jarrettsville Pike Phoenix 5. Social Security Number If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) Foreign Director 17 8/12/1991 Country) Maryland 1 XM 216-33-9862 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Baltimore Phoenix 1 Yes 2 X No MD 28a-f shov 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21131 USA 26 Glenberry Court Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 X Never Married 2 Yes 3 Widowed If Yes, Give Yea 4 Divorced Yes 2X No specify: Specify: White þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 h nent of Health and Mental Hygiene. ant: If item 27 is marked other than "r or other tranmatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Education Student 11 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Woolford Enjeen Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Glenberry Court Phoenix. MD 21131 David Woolford / Father Baltimore, Permit. Pages I and Department of Healt Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Hilltop Service Corp. 10/1/2008 Towson, Maryland Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service License 22. Name and Address of Facility Towson, M Ruck Towson Funeral Home, Maryland 21 . Inc. 1050 204) York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Finteral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 2 25. Was case referred to medical 26 Place of Death (Check only one) Be Other, examiner? DOA Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 V Yes No 28a. Date of Injury (Month, Day, Year) Sep 26, 2008 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto auto collision 1 Natural 0709 hrs Yes 2 V No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 13538 Jarrettsville Pike, Phoenix, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. September 26, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Day Year AM dward Weide 09 2 0730 2003 /Medical .6 4a. Facility Name (If not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death Social Security Number Boyview Medical Conto Battine C.
If Under 1 Year If Under 24 Hrs. N/A Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last b 1 □ M 2 □ F Months Days Min. Hours 213-05-5585 91 NOV. Director 1916 MD. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h. County in than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4901 FAIT AVE. 21224 UNITED STATES Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 ZWNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 XNo Specify WHITE δ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ATLANTIC SOUTHWESTERN Elementary/Secondary (0-12) 11THCollege (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed will be perment of Health and Mental Hygien. Important: If item 27 is marked other that any Injury or other traumatic events. PRODUCTION MANAGER BROOM CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH WEIDEL ROSE NOLAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL WEIDEL/SON 2204 WALSHIRE AVE., BALTIMORE, MARYLAND 21214 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 10/3/08 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenser 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only and cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** *Pancreatic* disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any barrier underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequent) of Hospital or Attending Physician: The law requires that the death certificate be execute and burial-trar Due to (or as a consequence of) the attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş page 2 should be 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy certificate 2 1 No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of After 1 Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deatle Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/01/2008 29c. License number in

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

FRED

31. Date filed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MARIE LeCLERC ZELLER Sept. 2008 3:55 /Medical p. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Maria Health Care Center Baltimore Baltimore 8. Date of Birth (Month, Day, Year)
April 16,1918 Maryland If Under 1 Year I If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🔯 F 213-01-6124 90 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6401 North Charles Street 21212 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2XXvo If Yes, Give Year or Dates: 1XXiever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2/CXNo Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) the Teacher Parochial School 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be partment of Health and Ments cortant: If Item 27 is marked I injury or other traumatic en William Zeller Magdalena Blank ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Feilinger, S.S.N.D. 6401 N. Charles Street Baltimore, Maryland 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury or once, Villa Maria Cemetery 10-2-08 Glen Arm, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Days urosens is disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Athera scleratic Condition were 27 1 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Yes 1 Inpatient 3□ DOA 2 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 □ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide To the.
within 24 hours.
To the Funeral Direct 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifie Mayland 00028673 Septonber 30, 2008 1 arder, W) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670) N. Charles St, Suite 5105 lander, mo Nga

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Anderton-Godfrey Juanita June 2008 Sectember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL Salisbui HICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 4/26/1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months Days 214-16-9083 1 □ M 2 🛛 F Hours 93 Director Virginia Usual Residence of Decedent 1∩a State 10h County 10c. City, Town or Location 10d. Inside City Limits ortant; if item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, Ite Medical Examination must be notified at 1X Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 922 Winding Way, Mallard Landing USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specifywhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cosmotologist Beauty 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley L. Hall Annie V. Chambers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or other trau Audrey B. Hook/daughter 904 Mt. Hermon Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/20/08 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens Signature of Funeral Service Licensee ²², Name and Address of Facility
HOLLOWAY Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical the ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy for in the past 12 months' Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐Mo 9 Unknown 9 II Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š ON S 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an & ZNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 npatient မှ 2 ER/Outpatient 3 DOA Director: After the in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, the Hospital or Attending Physician: death. Within 24 hours are Within 24 hours are To the Funeral Dir ٥

the death certificate be executed

Box 68760,

P.O.

and

the attending physician

signed by

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within 72 hours after death with the Maryland

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than "

Baltimore, Maryland

214-16-9083

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State Registrar

Medical

29a, Certifier (Check only one)

31. Date filed (Month, Day, Year) 2008 SEP 18

29b. Signature and title of certifie

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

	1 - State Registrar				Certin	ficate of	Death		g. No. 2 ()	08 3 147
sician edical	1. Decedent's Name (F			yer	Sr.			2. Date of Death	Day 15	Year 3. Time of Death
miner	4a. Facility Name (If no	t institution, give	e street and number	1 11	ster 41	o. City, Town, o	r Location of Death	ı		of Death .
eral etor	5. Social Security Number 219–14–90		ex 7. A	ge (In yrs. last		Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/23/192	Yea <i>r)</i>	9. Birthplace (State or Fore Country) Maryland
	Usual Residence of De	cedent b. County		10c. City. To	own or Locati	on	1			10d. Inside City Lim
Director	Maryland	Wicomi	ico	Sali	sbury					1 X Yes 2□
al Dire	10e. Street and Number 1213 Ta	aney Ave	֥			10f. Zip Code 2180)1	10	g. Citizen of t	What Country?
any injury or other traumants event, the monitor is to be not the property of other transfer once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 🎗		12. Was Decedent Armed Forces' 1 [X]Yes 2 □ If Yes, Give Year or Dates	No Armv	/ 1	Decedent of Hes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ce - American Indian, ck, White, etc. by: White
Completed	(Specify of Elementary/Seconda	Decedent's Ed	lucation	1	a. Deceden (Give kind life. DO		ation during most of wor d)	king 1		dusiness/Industry
Con Con	12 17. Father's Name (Firs				poult	ry	18. Mother's Nan	ne (First, Middle, M		ulture me)
To Be	Lester Bo						Rebec	ca DeLaug	hter	·
	19a. Informant's Name Kathryn Dy			1	19b. Mailing A 706	ddress (Street W. Main	and Number or Ru St., Fr	ural Route Number, uitland,	City or Town MD 218	, State, Zip Code) 26
	20a. Method of Disposi 1 🔀 Burial 2 □ C 4 □ Donation 5 □	remation 3 🗆	Removal from State			on (Name of ory or other place metery	:			- City or Town, State
once.	21. Signature of Funer	al Service Lio	Rever (250	²² H	ol Snow	Funeral Hill Rd.	Home Pro	fession ury, Mi	nal Association 21804
al Examiner	shock, or heart fa Immediate Cause (Fin- disease or condition resulting in death) Sequentially list conditi if atry, leading to hims a cause. Enter Underlyir Cause (Disease or inju- that initiated events resulting in death) Last	ons, finate and ry	b. Due to (or as	s a consequent	ce of):	PNE	MACON	S7 A		Interval Between Onset and Death
Physician/Medical	IF FEMALE: 23b. Was decedent prein the past 12 more 1 □ Yes 2 □ Nore 9 □ Unknown	nths?	d	2 ☐ Fetal de	ath 3 🗆 Ed	ctopic pregnanc	у			ate of delivery onth Day Year
p S	Part II. Other significat	nt conditions o	ontributing to death I	out not resultin	g in the under	rlying cause giv	en in Part I.		acco use con	tribute to the cause of death?
omp								24a. Was an autopsy perform 1 Yes 2	ed?	Were autopsy findings availa prior to completion of cause death? 1 □ Yes 2 ☑ No
To Be (25. Was case referred examiner?	to medical	Hospital:	ient 2 ER	/Outpatient	3 □ DOA Oth	or:	ath <i>(Check only one</i> Iome 5 ☐ Resider		her (Specify)
5 5	27. Manner of Death 1 Natural 5 2 Accident	☐ Pending investigation	28a. Date of Inj (Month, Da	ury 28	b. Time of Injury	28c. Injur Wor		28d. Describe hov		
rtific	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of In building, e	jury - At home tc. <i>(Specify)</i>	, farm, street,	factory, office		28f. Location (Str. City or Town,		ber or Rural Route Number,
ී	29a. Certifier 15 (Check only 25 one)	CertifyIng Ph Medical Exam	ysician: To the best niner: On the basis and manners	of examination	dge, death od and/or inves	ccurred at the ti	me, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and m te and place,	nanner as stated. , and due to the cause(s)
dical Ce						29c. Licens				ed (Month, Day, Year)
Medical Certificatio	29b. Signature and title	of pertifier		de us			06291	6 5	EATER	MBER 17,200

Registrar DHMH 17 Rev 1/2001 10 North Greene Street BALLimure, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

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PREET 31. Date filed (Month, Day, Year) SEF 18

SEF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** SEPTEMBER 28, 4:41 P M DORIS 2008 BAUGHER L /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth 7-11-194 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 T F 61 212-50-9521 MD Director Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination ust be invitined at 1 ☐ Yes 2 No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 1 169 Stonegate Drive 21702 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 X No If Yes, Give Year or Dates: Specify <u>≽</u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Baugher ၉ Thelma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 North Market Street Frederick, MD 21701 Kim Summers Daughter injury or other Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Crem. 9-29-2008 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licens 106 East CHurch St. Frederick, MD 21701 MO1176 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician HOUXID /Medical Due to (or as a con a guence of): Examiner 17 may Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Examir burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical the IF FEMALE nse i 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery ior. 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 **X** No Month Year 5 Other (specify) ned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?
Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>1</u>0 Hospital: 1∐Yes 2 🗹 No 1 M Inpatient 2 ER/Outpatient 3 DOA After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

DIL

State

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

You

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2008

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1)0062710

29d. Date signed (Month, Day, Year)

9/28/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician September 1550M HARRY RANDALL BAYNARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Laston Talbot raston 6. Sex 1 A M 2 □ F 8. Date of Birth (Month, Day, Year) JUNE 14, 1950 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. MARYLAND 58 220-48-6724 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, Ire Maclical Experiment nast be rutified at Director 1 XYes 2 □ No TALBOT EASTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 WILLIS AVE 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. <u>۾</u> Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 12 PROCESSOR NEWS PAPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MEDFORD MADISON BAYNARD VIRGINIA DULIN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA BAYNARD/MOTHER 205 WILLIS AVE., EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILL CEMETERY: 9/8/2008 SPRING EASTON. MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 F.50 8Troude Joseph 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acciden **Physician** elchovaswa disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial attending physician for use as the buria Physician/Medical as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy certificate performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur investigation 1 □Yes 2 □ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

law requires that the death certificate be executed Box 68760, P.0. Records, Hospital or Attending Physician: The Division of Vital the

Baltimore, Maryland 21215-0036

Baynard

TLS 2

> State Registrar

Year)

30. Name and address of person who completed

0

29b. Signature and title of certifier

32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

1mm 2195 Washington Street

			For State 1 - State Registrar	ate of Maryland / De <i>C</i>	epartment of F Certificate of L			ene 2008	3 3 1 4 7 4
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Zilla Jane Brown					r 16, 2008	8 7:35 P ^M
	Examin	er	4a. Facility Name (If not institution, give street	· ·		Location of Death		4c. County of Deat	h
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	Funeral Director		215 - 34-2262 1□M 2		Months Davs	Hours Min.	8. Date of Birth (Month, Day, March 25	Year) 7937	Maryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
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	r 28a	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	untry?
	th wit		409 Baltimore Stree	et	2191	L4		USA	
	ems	Funeral		/as Decedent Ever in U.S. rmed Forces?	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Spent	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
1215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show deal Evertine rust be notified at	δ	1 Never Married 2 X Married 1	□Yes 2 🕅 No Yes, Give ear or Dates:	1 □Yes 2 XNo	Specify:		0 " - "	nite
<u>ئ</u>	72 ho natur fical	eted	15. Decedent's Education (Specify only highest grade com	16a. D	ecedent's Usual Occup	ation	16	6b. Kind of Business/	Industry
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anc	- 9 2	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Surname)	
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ā,	s 1 ar		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other plac			Oc. Location - City or	Town, State
Ē	Page Tent c Int: If Iry or	1	1 ☐ Burial 2 【X Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al nom State	ard Funeral	i		ising Sun,	. Marvland
Baltimore, Maryland 2	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic e once.		21. Signature of Funeral Service Licensee		22. Name and Address				, 1.01) 1.011
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ecords,	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use a	ed by					1 ☐ Yes	2 ⊅ √00 3 □ Pr	robably 4 🗆 Unknown
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O TO	hysic his ce I direc	고 모	examiner? 1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 Residen	ice 6 Other (Spe	cify)
_	ing P	on:	27. Manner of Death 28 1	a. Date of Injury 28b. Tim (Month, Day, Year) 28b. Tim	ne of 28c. Injury Work	y at t?	28d. Describe how		
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	To the Hospital or Attending Physician: The law requires that the dividing 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	edical ((Check only 2 Medical Examiner: 0	n: To the best of my knowledge, on the basis of examination and/ound manner stated.	or investigation, in my o	pinion, death occurr	ed at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To th Comp	Me	29b. Signature and title of certifier	4.40	29c. License	e number	290	d. Date signed (Monti	h, Day, Year)
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_	4		30. Name and address of person who completed the state of	ted cause of death (Item 23a) (Ty	pe, Print)	man	st,	HGe	Md
	Sta Registra		31. Date filed (Month, Day, Year) SEP 1 8 2008	22. Registrar's Signature	arte	-			211

Physicia /Medica	
Examine	
Funeral	
Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.

Baltimore, Maryland 21215-0036

Physicia: /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

		Registrar				(<i>ier</i>	tificate of	Death			Reg. No	ید ں	00	J	1 4	10
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i.c		10e. Street and Nur						10f. Zip Code				_	tizen of	What Cou	ntry?		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician Dolores THEFESA 8:48 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Airy Kline FrEdERICK House Mount 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 26 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 78 213-26-5251 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examination at once. 14 Yes 2 □ No Director MD Frederick Brunswick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21716 1100 Peach Orchard Lane #201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2X No Specify þ Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Arnold Theresa Hoff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ann Byrum/daughter 6801 Yellowsheave Ct. Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 09/19/08 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going frome Cremation Service P.O. Box 784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic small cell cencer of lungs mths-yrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by disease arter 1 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy certificate perform 1 ☐ Yes 2 🗷 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Stother (Specify) NOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending n 24 hours after death.

Re Funeral Director; Afte fundetely filled in by the fundetententer. investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lember 18,2003

32

State Registrar Chan-Hing Ho, MO 6 10
31. Date filed (Month, Day, Year) 32. Segistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 1 9

gistrar's Signature

Sports

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CAND MED CNTK LILMIC 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1 ▼ M 2 □ F Months Hours July 20, New York Director 64 1944 228-58-8991 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modral Eximiner must be notified at one. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Montgomery Village 10g. Citizen of What Country? 10e. Street and Number Funeral 10331 Watkins Mill Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🕱 No Specify. Specify: þ 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor 5+ College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sroelov Blate Sonya Bernard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Lee Blate/Wife 10331 Watkins Mill Dr., Montgomery Village,MD.20886 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buria1 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 9/18/2008 Alexandria, Virginia ature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUBARACHNOID HEMORRHAGIC STROKE **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 2 10 1 ☐ Yes 1 □ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this Dat⊶f Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number AU4176435 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 15 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 GREENE BACTIMORE 21201 ST. MD MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 18 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da 09/10/2008 **Physician** 10:15pm Ruth Barrow /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F Director 283-50-5893 05/19/1914 Washington Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Silver Spring Maryland Montgomery 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20905 1704 Gamewell Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ੴNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Examinany injury or other traumatic event, the Medical Examinants. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White ò 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Rose Elizabeth Coberly Fred Coberly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1704 Gamewell Rd., Silver Spring, MD 20905 Beverly Tate- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 09/17/2008 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Brentwood, Maryland Fort Lincoln Crematory 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Lice 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Ye the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burial-transit Cecal Volvulus Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Dementia, Hypotension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ANo npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Suparich, D 0065 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, MD 20910 Barbara Supanich MD. 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 1 Registrar 2008 DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:09[™] Month Day Year Elisabeth M. Bruno September 15, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yes Nov. 11, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Year) 1 □ M 2 T F 098-16-9751 1913 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7715 Greentree Road 20817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: White Specify ¥X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Andrew Lukas Karoline Kolomber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn M. Bruno/Daughter 7715 Greentree Road, Bethesda, MD 20817 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 20 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) **20**08 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a, Part 1. Enter the disease, or complications that caused the death Approximate

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mcdical Evaning to penotified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hour after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the luneral director, page 2 should be detached for use as the burtial-transi

Division of Vital Records, P.O. Box 68760,

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	shock, or heart failure. List only	de cause on each line.	Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. CONCESTIVE HEAR	T FAILURG Cliser and Death
		Due to (or as a consequence of):	
liner	Sequentially list conditions, cause. Enter Underlying	b	
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	
edical		d	
Pnysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
2	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 25000
0	25. Was case referred to medical examiner?	26. Place of Death (C	
9	1 Yes 2 100	Hospital: 1 Inpatient 2 TER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
eruncation:	27. Manner of Death 1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (28b. Time of 28c. Injury at 28d Work? 1 Yes 2 No	Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)
9	29a. Certifier 1 Certifying Phy	visician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause(s) and manner as stated.

one) and manner stated

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

00057124

9116107

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Truong Bao, MD 8900 Old Georgetown Road, Bethesda, MD 20814

State Registrar

32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Syrd 9, 2008 ODER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** lisburg Rehab & Nursinactr Salisburg (1)icomico If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F MARYLAND Director 12-12-Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at MARYLAND Wicomico 1 Xes 2 No Director SOURU 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 21801 USA PREE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Maryland 21215-00 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nowe LABORER 07 permit. Pages 1 and 2 should be filed bepartment of Health and Mental Hygin Important: If item 27 is marked other Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ONAWAU BLANCHE ပ AMES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEDNEW is 21801 KEVIN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State CREMATORY 4 □ Donation 5 □ Other (Specify) 8-16-08 21. Signature of Funeral Service Licenses Name and Address A Facility \$ EWAR HOME 821 Salis Ma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pan /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ nours after death.

neral Director: After this y filled in by the funeral di After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H Robins, M.D. 31. Date filed (Month, Day, Year) State Registrar AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year AM **Physician** Month Kenneth Andrew Collins II 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Scall S bus, J If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 9, 1989 Hospice At the Lake mestal Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral ™** M 2□ F Yrs. Director MD 220-23-2273 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at Director 1 Yes 2 □ No MD Worcester Whaleyville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8922 Peerless Road 21872 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. د snould be filed within 72 hours after ut and Mental Hygiene. 1X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: **∂** Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic events. Kenneth A. Collins Theresa M. Mantello ပ 19a. Informant's Name/Relationship (Type. Print) parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. & Mrs. Kenneth A. Collins 8922 Peerless Rd., Whaleyville, MD 21872 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Staj 4 Donation 5 Other (Specify) 9/19/2008 Memory Gardens
2. Name and Add Salisbury, MD 2. Name and Address of Facility Lewis N. Watson Funeral Home 21. Signature of Funeral Service Licenses 1618 West Road, Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2**,** No 1 □ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐Pending investigation 1 X Natural 24 hours after death. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated. (Check only within 2 the 29b. Signature and title of certifier

State Registrar

BELLOSO, M.D.: 5302 GREGORIO M. 31. Date filed (Month, Day, Year) 2008 SEP 18

39. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

32. Figistrar's Signature

CHINABERRY DR. SALISBURY, MD 21801

D 29505

08-07328 Jason Carter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 31482

			For State	-	Cer	tificate o	f Death					Reg. No.			
	Physicia		egistrar I. Decedent's Name (First, Midd	lle,Last)							. Date of De Month		Year		3. Time of Death 1130 hrs
P.	¹ Examit		Jason Alan	Carter							Month Septemb				11301115
			a. Facility Name (if not institution				4b. City, Tow		cation of D	Death			c. County of Washing		
			839 Pine Street	504 Lynne	Haven D	r	Hagerst				1	1			riogo (State of
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1	_	If Under 2	24Hrs Min.	8. Date of I	Birth(MM	/DD/YYYY)	Foreign	
	Director		220-94-5184	1XXM 2 F	2	g Yr	Months 3.	Days	Hours	IVIII I.	02/17	/19	79	Cou	Mary land
			Usual Residence of Decedent	AA _										- 7	0.1.0
	any		10a. State 10b. County		10c. City,	Town or Loca	tion								10d. Inside City Limits
	≜	٠, ا	Mary Land Was	hington	l l	Hage	erstow	n							1XX Yes 2 No
1	Aaryland 28a-f show 1 at once.	흱	Maryland Was 10e. Street and Number	irrigion		1109	10f. Zip Co					10g. Ci	tizen of Wh	at Count	try?
Ch	r 28	Director						2174	10					USA	
N	Le filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be nofified at once.	L	839 Pine St	12 Was De	cedent Ever in U	S 13 W	as Decedent	of Hisp	anic Origin	1? (Spe	cify Yes or	No-	14. Race		can Indian, Black,
1	th wi)je	11. Marital Status 1 X Never Married 2	Married Armed F	Forces?	.o. If	Yes, specify	Cuban,	Mexican, F	Puerto F	Rican, etc.)		White	etc.	
	r dea or it	Funer		1 Yes	2 X No	1	Yes 2X	Χ _{No}	specify:				Specify:	W	hite
	ded within 72 hours after Hygiene. other than "natural", the Medical Examiner.	à	Widowed 4 D 15. Decedent's Education (Sp	or Dates:		16a Decede	ent's Usual Oc	ccupatio	n (Give kir	nd of wo	ork done	16b	Kind of Bu	siness/Ir	ndustry
	hour: natu Exan	P	Elementary/Secondary (0-12		(1-4 or 5+)	during	most of worki	ng life. I	DO NOT us	se retire	ed)				7.
ي	n 72	Completed	1 1	oonege ,	(1 4 6. 6 7	Heavy	Equip	men-	t Ope	rato	or	- 1		Pav	ing
څ	within jene.	Ē	17. Father's Name (First, Middl	lo Laet)								e, Maide	n Surname)	
ĸ	Hyg dot		***		au a a I				Kimb	erly	y Sue	e C	arter		,
MD 24245_0036	hould be filed within 7.7 hould be filed within 7.7 is marked other than afte event, the Medical	o Be	Richard Cu 19a, Informant's Name/Relation	nshin (Type Print)	Jugai	19b. Maili	ng Address	(Street	and Numb	er or R	ural Route I	Number,	City or Tow	n, State	, Zip Code)
,	should I and Mer	۲			o. r		Pine S								
			Kimberly Mye 20a. Method of Disposition	rs - MOTTI	20b.	Place of Disp	osition (Name	of cem	netery,	<u> </u>	Date	20	c. Location -	- City or	Town, State
9	Pages 1 and 2 should be fill ment of Health and Mental I fant; If item 27 is marked or other traumatic event,		1 Burial 2 X Cremati	on 3 Removal	f Ct-t-	crematory or	other place)				74/00	م ا م	• 111	la	Manuland
5	Page Page nent c		4 Donation 5 Other		Sm	ithsbu	rg Cre	mate	ory	09/.	30/200	0812	MITHS	burg	, Maryland
=	Daltimore, permit. Pages 1 at Department of Hec Important: If ite injury or other tr	1	21. re of Funeral Servi	ce Licensee		139	৬৮৮ ৮৫	ddFess	Kies sign	Hoi	me, P	.A.	111		+ MD 21705
Ω	D EAFE		Jalle M				25 S.	Con	ococh	eag	ue ST	· W I	hock or he	Spor	+, MD 21795
· ·	hysician		23. Part I. Enter the disease, failure. List only one cau	or complications that se on each line.	caused the deat	h. Do not ente	r the mode of	ayıng, :	such as ca	Irdiac oi	respiratory	airest, s	shook, or he	·Car t	Between Onset and Death
	Medical		Immediate Cause (Final disea	TT	in intox	icatio	n								Deau
	_xaminer		or condition resulting in death		a consequence	of):									
			Sequentially list conditions,	b						_	_				
		ner	if any, leading to immediate cause. Enter Underlying Cau	se	a consequence	of):									
		Examiner	(Disease or injury that initiated	d	a consequence	of):									
	ted I Insit	Ä	events resulting in death) Las	31								100	-		
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	760, icate be of physicia the buria	edi	IF FEMALE:	23c If ve	s, outcome of pre	egnancy	4 10/9	/00	11				23d. Date of	of deliver	ry
į	frat ificat ig ph	1	23b. Was decedent pregnant i	n the 1 Liv	e birth	2	Fetal death	3	Ectopic	pregna	ancy	1	Month		Day Year
•	cert r cert endir use a	cia	past 12 months?	4 Pre	egnant at time of		Other (Spec					_			
	Division of Vital Records, P.O. Box 68 ttal or Attending Physician: The law requires that the death certificats after death. In a Director. After this certificate has been signed by the attending lind in by the fineral director, man 2 should be detached for use as law.	Physiciar			known						220 [Did toba	CO USA CON	tribute to	the cause of death?
	at the diby t	P	Part II. Other significant cor	nditions contributing	g to death but no	t resulting in th	ie underlying	cause (given in Pa	irt i.					obably 4 🗸 Unknown
(es the signe	d by	Cocaine use								1		151111= 425	9.00	the state of the s
	ds require	ete										Was an autopsy		prior to	autopsy findings available completion of cause of
	law law has l	=										performe Yes 2		death?	
	The ficate	Completed		end to				26 Place	e of Death	(Check					
	cian: certi	Be	25. Was case referred to med examiner?	Hospital:	Inpatient 2	ER/Outpati		OA	Other ₄		ng Home	5 Re	sidence 6	✓ Oth	er: Scene
	Physical Physical Control of the Physical Control of t	2	1 Yes 2 No 27. Manner of Death		ate of Injury	28b. Time			ry at Work				v injury occu		
	Afte	Ë	1 Natural 5	(M	onth, Day,Year)				Yes 2X		unk				
	ttend french death stor:	aţi	2 Accident	Pending Fnd	9/26/0 Place of Injury - A	8 Fnd		am			28f Loca	tion (Stre	et and Nun	nber or F	Rural Route Number, City
	or A or A of A or A or A or A	iji Ei	3 Suicide 6 X	Sould not be	found	t nome, tarm, s	ate dw	e11i	ing	ic.	or To	wn, Stat	e)504 _M I	ynn	e Haven Dr
	pital ours a eral	Certification:	4 Homicide	determined (Spec	шу)						-				
	Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certification that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending complement Birderor. After this certificate as seen signed by the funeral director ages 2 should be detached for use as:	<u> </u>		g Physician: To the Examiner:On the ba	best of my knowl	edge, death o	courred at the	time, d	iate and pla n death or	ace, an	d due to the at the time.	date an	s) and mann d place, and	d due to	the cause(s)
	To the I within 2 To the I	Medical	one) 2 Medical	and mann	er stated.	n and/or nives									Nonth, Day, Year)
	P S P C	Ž	29b. Signature and title of ce	rtifier	V.D		29		se number						
			his	w, M	, 0,			O.C	.M.E.				Septemb 	CIZI,	
			30. Name and address of pe	rson who completed	cause of death (I	tem 23a)									
7/4	-0		Ling Li, MD Assi	istant Medical E	xaminer 1	11 Penn S	treet, Balti	more,	, MD 212	201					
		State	31. Date filed (Month, Day, Y		. Registrar's Sign	nature	121								
	Reg			2008	Gear S	Gna	1.3								
DH	HMH 17 Rev	1/2001		49		ÖRIGI	NAL						DCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Day Year **Physician** Ам 5:50 Thomas Alfred 10 2008 /Medical Church Sept 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 502 Senior Way Social Security Number Wicomico Salisbury Birthplace (State or Foreign Country) 6 Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F Director 218-20-4343 Usual Residence of Decedent February 25 1925 Maryland 83 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show tX☐Yes 2 ☐ No Director Maryland | Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 2 USA 21801 502 Senior Way Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 Is marked other than any injury or other trainmant. 12th truck driver/self-employed Seafood Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Church Townsend Florence William ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 502 Senior Way, Salisbury, Maryland 21801 Sonia S. Church/wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sept. 16, 2008 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD JOLLEY MEMORIAL CHAPEL, P. A. 21801 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Approximate Interval Between Onset and Death s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Immediate Cause (Final **Physician** 7 disease or condition resulting in death) Oronan /Medical Due to (or as a consequence of): Examiner Due to (br as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine **Hospital or Attending Physician:** The law requires that the death cerificate be executed 24 hours after death. Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed' certificate 2 🗆 No 1 Yes 2 No 1 Yes Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 垣 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel and manner stated 29b. Signature and title o

Registrar

State

30. Name and address

31. Date filed (Month, Da

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person who completed cause of death (Item 23a) (Type, Print)

DO

egistrar's Signature

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Power 5t, Salisbury Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 **Physician** 0509 A M Ruth Porter Clift /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula RegioNAL SALISBUR WICOMICO if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛣 F Director 217-14-8605 86 8/7/1922 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits in than "natural", or items 23a or 28a-f show Director 1⊠Yes 2 No MD Somerset Princess Anne 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 30343 Pine Street 21853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No 2 Specify: 3 Nidowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Board of Education <u>dietician</u> is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Carroll A. Parks Bessie Holland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau James H. Porter, Jr. (son) 9903 Carrolton Court, Westover, MD 21871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Vernon Cemetery 8/13/2008 Princess Anne, MD 22. Name and Address of Facility Signature of Funeral Service Licenses Holloway Funeral 103 Linden Ave., and A Home, Professional Association Pocomoke City, MD 21851 CFSP Compson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** OBSTRUCTIVE CH KONIC ULIVONAKY /Medical Due to (or as a consequence of): Examiner Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical attending IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) P.O. the 9 D Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? ONGESTI 24a. Was an autopsy perform 2 12 No 217No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner 1 Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident after death Director: 3 Sulcide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month

Day, Year)

14

2008

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6/11

egistrar's Signature

32.

08-07107 Scott Campbell

P

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Maryland / Department of He	alth and Mental Hygiene

2008	3		4	8	2
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		1- For State Registrar		Cert	tificate of	Death			R	eg. No.		0 0110
Physici ledical Exami	an/	Decedent's Name (First, Midd Scott	lle,Last)	Campb	oell				Date of Dea Month Septembe	th Day Yes er 17, 2008		3. Time of Death 1737 hrs
		4a. Facility Name (if not institution Union Hospital	on, give street and nu			b. City, Town, o Elkton	r Location of	Death		4c. County Cecil	of Death	
Funeral Director		5. Social Security Number 222-70-8941	6. Sex	7. Age (In yrs. la:	st birthday)	If Under 1 Ye Months Da		24Hrs. 8		1972	Foreign	place (State or htry) Delawar
any		Usual Residence of Decedent 10a. State 10b. County			Town or Location	DD.	<u> </u>		3/4/	1972		10d. Inside City Limits
* o	ctor	MD Ceo				ake Ci	ty		1	0g. Citizen of W		1 Yes 2 No
vith the Maryland s 23a or 28a-f sho e notified at once.	ral Director	5 Mallard I		cedent Ever in U.S	S. 13 Was	219 Decedent of H	<u> </u>	n? (Speci			USA	
after death with the Maryland al", or items 23a or 28a-f sh iner must he notified at once	y Funeral	1 Never Married 2 XM		orces?	If Ye	es, specify Cuba	n, Mexican, I			Whit	whi	
2 hours "natur	leted by	15. Decedent's Education (Spe Elementary/Secondary (0-12)			during mo	's Usual Occup est of working lif	e. DO NOT u	se retired)	16b. Kind of B		
5-00 lled wit Hygien I other the M	Be Complete	10 17. Father's Name (First, Middle Paul E. Can			Build	ing Ma	18.Mother's	Name (F	irst, Middle,	Manu Maiden Surname Cregg	e)	ring
Me Me	To B	19a. Informant's Name/Relations Samantha J.	ship (Type, Print)	l/Wife	19b. Mailing 5. Ma Chesa	Address (Stre Ilard apeake				mber, City or Tov		Zip Code)
altimore, MD mit. Pages 1 and 2 sho partment of Health and portant: If item 27 is ury or other traumati		20a. Method of Disposition 1 X Burial 2 Crematio 4 Nonation 5 Other S		rom State Gr	lace of Disposi	tion (Name of c er place) wn Mem	emetery.)ate	20c. Location	- City or T	
m 50 ₹ 15		21. Sign thre of Funer 5 rice 23a. Part I. Enter the disease, o	CC	0 0 4 4 2	22. N Be	ame and Addres	Funer laski	al F	iome hway	of New	ark rk,	DE 19702 Approximate Interval
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	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	oscleroi		iovascu	lar di	iseas	se		- 14	
xecuted n and - transit		events resulting in death) Last X UNPENDED	Due to (or as a	consequence of	,	7, perM	E, g88	34 10)/10/0	8 TT		
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed retearth. retearth. by the funeral director, page 2 should be detached for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	23c. If yes,	nant at time of dea	2 Fet	al death 3 ner (Specify)	Ectopic	pregnanc	у	23d. Date o	f delivery Da	ay Year
rds, P.O. B v requires that the d s been signed by the should be detached	ð	Part II. Other significant condi			sulting in the u	nderlying cause	given in Par	t I.				ne cause of death?
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Vital Reysisian: The his certificate director, page	Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		Other		y one)	Residence 6	Other:	
ion of vending Physeath.	ation: To	27. Manner of Death 1 X Natural 5 Pen	28a. Date (Month estigation	of Injury n, Day,Year)	28b. Time of Ir	· ·	ury at Work?	- 1	3d. Describe	how injury occui	rred	
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fire	Certification:	3 Suicide 6 Cou		e of Injury - At ho	me, farm, stree	t, factory, office	building, etc	. 28	or Town,		ber or Rura	al Route Number, City
To the Hos within 24 h To the Fur completely	Medical (one) 2 Medical Exa	Physician: To the be aminer:On the basis and manner s	of examination an		on, in my opinio	n, death occ			and place, and	due to the	cause(s)
	Z	29b. Signature and title of certifi	Deg	Mo			.M.E.			29d. Date sign		
		30. Name and address of person Tasha Greenberg MD	D. Assistant M	ledical Exami	iner 111 l	Penn Street	, Baltimor	e, MD 2	21201			
Si Regis	ate trar	31. Date filed (Month, Day, Year)	9 2008 32. R	edstrar's Signatur	"H A	rede						

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			Decedent's Name (First, Middle, Las	t)			tinoa		Journ		2. Date of De	Reg. No.		3. T	ime of Death
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-5	S Z	20	Oakland Nursing &	Rehab Ce	enter		08	aklan	d			G	arreti		
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н	Director		215-01-9297	□M 2)X□F g	93	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept.			Pountry) aryla:	nd
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes If Yes, Give Year or Dates:	?	i	Was Dece If Yes, spo 1 □ Yes		ispanic Orio in, Mexican Specify:	gin? (Spec i, Puerto F	cify Yes or No Rican, etc.)		4. Race - An Black, Wi Specify:	nite, etc.	
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-	alth a 27 is		Mr. Bernard Cherr	y, Son		1897	0 Gar	rett	High	way,	0ak1aı	nd, M	D 2155	50	
ē,	s 1 a of Hear item othe		20a. Method of Disposition	-	20b. F	Place of Dispo	sition (Na	me of	-01	Da	ate	20c. Loc	ation - City	or Town, St	tate
E O	Page ent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		s 1	mberla:				9/20.	/2008	Cum	berlar	nd. M	D
Baltimore,	mit. I		21. Signature of Funeral Service Licen		100.										-
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	-		23a. Part1. Enter the disease, or comp	olications that couse	d the deatl									Appr	oximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final			r's ty	mo	domo	ntin					Onse	val Between et and Death
1	/Medical		disease or condition resulting in death)	a. Alziie Due to (or as			ype	aeme	HUId					т у	r
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ğ	equire en siç suld b	pa	Hypertension								1 🗆	Yes 2] No 3 □	Probably	4 □Unknown
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Ž	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 2X No	Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatier	nt 3 D	OA Othe			ne 5□Resi		□Other (St	necify)	
0	ding Physician: The In. After this certificate he funeral director, page	n: T	27. Manner of Death	28a. Date of Inju	ury	28b. Time o		28c. Injury Work			8d. Describe			ocity)	
jo	Attending r death. ector: After by the funer	atio	1	(Month, Da	ay rear)	Injury	М		r Yes 2∐1	No					
Division	Attendi r death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Zoe. Place of III	jury - At ho	ome, farm, str	eet, facto	ry, office		21	Bf. Location (Number or	Rural Rout	te Number,
Ö	al or A s after al Direction by	Cert	4 Entrinside	building, e	itc. (Opecii)	<i>y /</i>					City or To	vn, State)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	ysician: To the best	t of my kno	wledge, deat	h occurred	at the tin	ne, date an	d place, a	nd due to the	cause(s)	and manner	as stated.	
	n 24 n 24 ne Fu	Medical	(Check only 2☐ Medical Exam	niner: On the basis of and manner si	of examina tated.	ition and/or in	vestigatio	n, in my o	pinion, dea	th occurre	ed at the time,	date and	place, and d	ue to the o	cause(s)
	Vithi Withi To the	ž	29b. Signature and the of certifier	. 1) 19				c. License					signed (Mo		Year)
			1 / Junala	tuhl	52			D300	135			09	-19 - 2	800	
			30. Name and address of person who	completed cause of	death (Item	n 23a) (Type,	Print)								
			Donald R. Rich					oria	1 Dr	ive	0akla	and,	MD 2	1550)
	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	rar's Signa	ıture									
	Registr	rar	SFP 2 2	2008		10	Book	F							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 7:10 P.M September 19 2008 Carrico Helen Ruth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Oakland Nursing & Rehab Center Oakland If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 □ M 2 🕅 F West Virginia April 19 1927 Director 233-42-8534 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 √Yes 2 No Director 0akland MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21550 United States 139 Oakhall Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No Specify: þ 3 Widowed W Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Nursing Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Snyder Lula Willis Dumire 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15889 Garrett Highway, Oakland, MD 21550 Diane Frantz, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of once, N Burial 2 Cremation 3 Removal from State Ferndale Cemetery 9/23/2008 Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A.
21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licenses Katherine Sweet 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical

attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, sate has been signed by the page 2 should be detached funeral director, After this n 24 hours af er death.

ne Funeral Director: Affoletely filled in by the fur within 24 hor To the Fune completely fi

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death with

Pages 1 and 2 should be filed within 72 hours after

of Health and Mental Hygiene. item 27 Is marked other than

altimore, Maryland 21215-0036

State Registrar

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2008

Day,

Wemorial Drive California, US 21550

32. Registrar's Signature

			1 - State of Mar Registrar		artment of F rtificate of			jiene 2 (800	31488
	Physici /Medi		Decedent's Name (First, Middle, Last) Max Edward CLOPPER				2. Date of Dear	th Day	Year	3. Time of Death
-	Examir		4a. Facility Name (If not institution, give street and number) Washington County Hospital			r Location of Deat		4c. County	of Death	n 4 10p
	Funeral Director		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)			(Month, Day)		ace (State or Foreign
	the Maryland 28a-f show	Director	Usual Residence of Decedent	10c. City, Town or Lo	ncastle		1	Og. Citizen of		od. Inside City Limits 1 □ Yes 2 ☑ No
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nd 212	e filed withi al Hygiene. I other thar went, the N	Be Comp	Elementary/Secondary (0-12) College (1-4or 5+) 10 0 17. Father's Name (First, Middle, Last)		r Inspect	or	me (First, Middle, I		lroad	
laryla	2 should be and Ments Is marked raumatic e	70	Herman Edward Clopper 19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	Hattie and Number or R		, City or Town,	State, Zip	Code)
Baltimore, N	Pages 1 and nent of Healtl int: If Item 27 iry or other t		Margaret Clopper - Wife 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crei	73 Mercer position (Name of matory or other place wn Mem. P	ce)	Date	20c. Location -	City or Tov	
Balti	permit. Departr Imports any Inju		21. Signature of Funeral Service Licensee	2:	2. Name and Addre	ss of Facility M	innich F	uneral	Home	
	Physician / Medical Examiner the private t	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause on each line. Due to (or as a condition of the cause o	consequence of): Charles of the consequence of): Charles of the consequence of the cons	ter the mode of dying the second of the seco		c or respiratory arm	est,		Approximate Interval Between Onset and Death
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Records, P.	requires that the seen signed by th nould be detache	by	Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	, e		e cause of death?
Hec	aw 1s b	Completed	<u> Lestatis</u>				24a. Was ar autops perform 1 □ Yes 2	y ned?	prior to com death?	sy findings available pletion of cause of
or vital	hysiclar this certif al directo	To Be		2 🗆 ER/Outpatier		er: 4 ☐ Nursing H	ith <i>(Check only one</i> lome 5 ☐ Reside	nce 6 Oth)
DIVISION OF	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Y. 6 Could not be determined 28e. Place of Injury building, etc. (M 1 🗆	y at ⟨? Yes 2 □ No	28d. Describe ho	reet and Numb		Route Number,
	e Hospita 124 hours e Funeral letely filled	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of real conditions of examiner: On the basis of examiner stated and manner stated	kamination and/or in	n occurred at the tir vestigation, in my o	me, date and place pinion, death occu	e, and due to the carred at the time, da	ause(s) and ma	anner as sta	ated. the cause(s)
.	To th Vithir Comp	Me	29b. Signature and title of certifier	•>	29c. License	o 564/3	29	9d. Date signer	d (Month, D	ay, Year)
			30. Name and address of person who completed cause of deat	h (Item 23a) (Type,	Print) Opal C	DURT	Haers3	tan i	mo :	21740
ı	Stat Registra	.6	31. Date filed <i>Month, Day, Year)</i> SEP 2 2 200	Signature	Sol	~ - 01-1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 18,2008 6:10 PM otember BETTY LUCILLE CRIDER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
JAN. 2, 19 **Funeral** Months 1 □ M 2 🛛 1934 MARYLAND Director 214-30-1680 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Exprimer must be notified at 1X Yes 2 □ No Director WASHINGTON MARYLAND KEEDYSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21756 U.S.A. 86 SOUTH MAIN STREET death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. Specify: 3 ☐ Widowed 4 X Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRESSER CLOTHING MANUFACTURE 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f SARAH CATHERINE GRIFFITH Pages 1 and 2 should 2 GEORGE THEODORE ROHRER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. 16916 READING DRIVE, WILLIAMSPORT, MARYLAND 21795 DEBRA GLENN/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/22/2008 KEEDYSVILLE, MARYLAND FAIRVIEW CEMETERY 21. Signature of Funaral Service 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21713 Paul M. Dean 7606 Old National Pike, Boonsboro, MD 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final eoch so vavoulax Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as t signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent premant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant do itions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? of Vital Records, \$ neymome 1 FYes 2 No 3 Probably 4 Unknown Completed Obs tomb 24a. Was an 24b. Were autopsy findings available prior to completion of cause of home certificate has birector, page 2 s autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of cert

5H-6

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma		Certificate of			.No.2008	3 49
	Dhusia		1. Decedent's Name (First, Middle, La	ist)				2. Date of Death Month	Day Year	3. Time of Death
	Physic /Medi		Filippo Antonio D'A	vanzo				September		2:10 a M
	Exami	ner	4a. Facility Name (If not institution, gire	ve street and number)		4b. City, Town,	or Location of Death	1	4c. County of Dea	ith
			Suburban Hospital 5. Social Security Number 6.5		d t-11:0	Bethesda			Montgomery	
	Funeral Director		217-44-2775	Sex 7. Age 7. Age 84	(In yrs. last birtl	Months Days		8. Date of Birth (Month, Day, Y		thplace (State or Foreign ountry) Italy
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary	ğ	Maryland Monto	nmore:	C+ 1	Oncedon or				1 ☐ Yes 2 ☑ No
	1 the	Director	10e. Street and Number	Ollery	STIVEL	Spring 10f. Zip Code		10g	. Citizen of What C	ountry?
	3a o	<u>e</u>	1128 Arcola Aven	ue		20	902	US	≅7∆	
	deat	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of If Yes, specify Cut			14. Race - Am	
5-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Even	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 1 □ Yes If Yes, Give Year or Dates:	o	1 ☐Yes 2 🔀 No		o nican, etc.)	Black, Whi	
5-0	72 hc 'natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Occu	pation during most of work	kina 16	b. Kind of Business	/Industry
121	within iene. than "	ם	Elementary/Secondary (0-12)	College (1-4or 5	F)	Give kind of work done life. DO NOT use retire				
121	filed withir Hygiene. other than ent, the Me		12 17. Father's Name (First, Middle, Last	·)		Custom Tailor	_	or ne (First, Middle, Mai	Clothing	
Maryland	d be f ental l ed of	Be		,			16. Mother's Nan	ie (riist, middie, mai	iden Surname)	
Z	should nd Me mark mati	욘	Frank D'Avanzo 19a. Informant's Name/Relationship	(Type Print)	19h	Mailing Address (Stree		a Bozzella	Pity or Town State	Zin Code)
Ma	s 1 and 2 should be file if Health and Mental H item 27 is marked oth other traumatic even		Anna D'Avanzo/Wife	Type: 1 mily	135.	1128 Arcola 2				Zip Code)
ē,	f Heal		20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other pla			c. Location - City or	Town, State
Ę	Pages nent of the sunt: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.			Heaven Cemete	Sept	20,		
altimore,	보보면를 .		21. Signature of Funeral Service Lice		1 0400 01	22. Name and Addr	ess of Facility		lver Spring	,Maryland
ä	Depa Impo any ii		1 Cinchen	a Cole		Francis J.	Collins Fur	meral Home I W., Silver	nc.	20001
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	tic tions that caused	the death. Do no	ot enter the mode of dy	ing, such as cardiac	or respiratory arrest	string, Mo	Approximate Interval Between
4	Physician	8 9	Immediate Cause (Final disease or condition	_	 Iract Infe	oction				Onset and Death
	/Medical		resulting in death)		consequence of					
	Examiner		Sequentially list conditions	b. Pneumoni	a					
	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	·):				
	ecut and -trans	Examiner	that initiated events resulting in death) Last	·	nal Failur consequence of					
68760,	rtificate be executed ng physician and as the burial-transit			Due to (or as a	consequence of)-				
387	rtificate ng phys as the	Medical		d						
Вох	£ 5, a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	elivery
B	Physician: The law requires that the death ce this certificate has been signed by the attendi ral director, page 2 should be detached for use	Physician/	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at		3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		Month	Day Year
P.O.	at the de by the tached	hys	9 🗆 Unknown	9 🗆 Unknown						
Ś	res tha signed be dei	by	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause gi	ven in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
ord	v requir been s should	ted						1 🗆 Yes	2 ∑ No 3∏ F	robably 4 Unknown
ec	faw r las b	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u>=</u>	: The law cate has page 2 s	ဦ						performed	d? death?	s 2□No
Vita	siclan: Ti certificate irector, pa	Be	25. Was case referred to medical examiner?	I I - o - it - i				th (Check only one)		
of Vital Records,	Phys this (은	1 Yes 2X No			Datient 3 DOA		ome 5 Residence		ecify)
UC.	ding l J. After funer	io	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Ti Yea <i>r)</i> Inj	ury Wo		28d. Describe how	injury occurred	
isi	death death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not b	e OPo Disco of Iniv	ry - At home farr	n, street, factory, office	Yes 2□No	28f. Location (Stree	at and Number or E	ural Pouto Number
Division	after after Dire	Certification:	4 Homicide determined	building, etc	(Specify)	n, etroet, lactory, emice		City or Town, S	State)	urar noute Number,
	spita hours neral y filled		29a. Certifier 1 X Certifying Pt	nysician: To the best o	f my knowledge,	death occurred at the t	ime, date and place	, and due to the cau	se(s) and manner a	is stated.
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and	or investigation, in my	opinion, death occu	rred at the time, date	and place, and du	e to the cause(s)
	To the vithing to the complete of the complete	M	29b. Signature and title of certifier			29c. Licen	se number	29d.	. Date signed (Mon	th, Day, Year)
	[]		▶ Wht			000	61302	Ü	1/16/08	
	1 -		30. Name and address of person who			ype, Print)			1	
						ive, Rockvill	e, MD 20850		`	
	Sta		31. Date filed (Month, Day, Year)	32. Registra		arts)				
	Registr	ar	SEP 17 2008	J. Selfer	15 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#80erFH 9/17/08, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Voar 101 09 20 12 200% /Medical 4a. Facility Name (If ηot institution give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Par a Kouce If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 06 15 Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) Funeral Min. Months Days Hours 1 □ M 2X F 95 Yrs 578-10-2577 Director Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1√2 Yes 2 No notified Directo 28a-f DC Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? be. Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or? 1400 Florida Ave. N.E. #315 ms 23a (20002 USA Funeral ural", or items 2 i Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: Black Completed by 3 NVidowed 4 Divorced 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Providence Hospital 12th. event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Item 27 Is marked other traumatic ev 2 Robert Lee Carrie Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris V. Frazier/Granddaughter 248 Possum Ct. Seat Pleasant, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or c 1 → Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. | 09-19-2008 | Silver Spring, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 4217 9th. St. N.W. Washington, D.C. 20011 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mona /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed Exami burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 1□ Yes Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Vatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D0055 MD ed cause of death (item 23a) (Type, Print) 30. Name and address of person who com-MD 31. Date filed (Month, Day, SEP 1 Year) 32. Règistrar's Signature State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Charles Francis DeFilippo, Sr. September 16, 200B 3:00 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1312 Milestone Drive Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 579-14-0059 Director 85 Oct. 18, Washington, DC 1922 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 TNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1312 Milestone Drive 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 TNo Specify þ Specify: White Year or Date 1:943-46 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 10 Manager Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicola DiFilippo Antonia Pasante ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary DeFilippo/Wife 1312 Milestone Drive, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Sept. 2008 16 Metropolitan Crematory 4 Donation 5 DOther (Specify) Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bladder Cancer disease or condition resulting in death) 20 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Lisease of Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 1.24 hours after death.

e Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 687600 Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 □Yes 2**X** No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 21€NNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 28d. Describe how injury occurred 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45880 September 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive, Rockville, MD 20850 Leon Hwang, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar

		For State Registrar	State o	f Marylan		artment of rtificate of	Health and I		2111	08 31491		
-		Registrar 1. Decedent's Name (First, Middle,	(ast)		Cer	lilicate of	Dealli	2. Date of Dea		3. Time of Death		
Physicia			,	0.14				Month	Day Y	ear		
/Medic Examin		Catherine 4a. Facility Name (If not institution,	C. Ey1			4h. City. Town.	or Location of Death		oer 12 20 4c. County of			
Examin	er	Northampton Ma	•				lerick			erick		
Funeral			6. Sex	7. Age (In yrs. i	last birthday)	If Under 1 Year	r If Under 24 Hrs.	8. Date of Birtl	n 9	. Birthplace (State or Foreign		
Director		217-16-2947	1 □ M 2 🕱 F	86	Yrs.	Months Days	Hours Min.	(Month, Day	1, Year)	Country) Maryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent										
	_	10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits		
8a-f	Director		erick		Fred	lerick				1 ☑ Yes 2 □ No		
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s 23¢	Funeral	303 Catoctin A		adant Ever in III	C 140.1		1701		United S			
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ırs af Il', or Xami	by F	3 Widowed 4 Divorced	If Yes, Giv	ve		I□Yes 2⊠ No	Specify:		Specify:	White		
2 hou	ted	15. Decedent			16a. Deced	lent's Usual Occu	upation		16b. Kind of Busin	ness/Industry		
hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1-4or 5+)	(Give life. L	kind of work done OO NOT use retin	e during most of wor ed)	rking				
d wit	No.	11	J	. 101 017	Cafe	eteria W	orker		High	n School		
al Hy sal Hy soth	Be (17. Father's Name (First, Middle, L	.ast)				18. Mother's Nan	me (First, Middle,	Maiden Surname)			
Ment A	10	Sourren L. Welt	:y				Rosa	Mulican				
2 short and ls m		19a. Informant's Name/Relationsh					et and Number or Ru					
l and fealth m 27 her tr		Joseph K. Eyler	., Jr. / S	Son			Avenue					
Pages 1 nent of 14 nt: If iter iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from		emetery, cren	sition (Name of natory or other pl	ace) Sep	tember	20c. Location - Cit	ty or Town, State		
t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Sp		Mt.	. Olive	et Cemet	ery 17	, 2008	Frederick	k, Maryland		
permit. Departn Importa any Inju		21. Signature of Funeral Service L	licensee							omes, P.A.		
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Examiner			Due to	(or s a consequ	ence of.	Do	mentia			l Man		
	ler	Sequentially list conditions, if any leading terms that	b. — Due to	or as a consequ	uence of):		. ,			Jem		
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an an rial-tr	Exa	resulting in death) Last	Due to	(or as a consequ	uence of):			-				
cate be executed physician and the burial-transit	dical	,	d									
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leath certific attending p	Physician/M	23b. Was decedent pregnant	1□Live b	tcome pf pregna oirth 2 ☐ Fetal	Ideath 3	Ectopic pregnan	су		23d. Date of			
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uires that the de signed by the a Id be detached f	d by	Ů	ŭ		3	, , ,		1 🗆 Y		☐ Probably 4 ☐ Unknown		
w requir been si should I	Completed			·				24a. Was a				
he lar e has ge 2	E D							autop perfor	sy pric	re autopsy findings available or to completion of cause of ath?		
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ysicia s cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA OI	Un	ath (Check only or	ence 6 □Other	(Specify)		
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ath. or: Af	atio	1 Natural 5 Pending 2 Accident investiga	ation	ar, Day rear)	Injury		∃Yes 2 ☐ No					
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned Zoe. Place	of injury - At ho ing, etc. (Specify		eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
ital o Irs aft ral Di lled ir	Če											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical E	examiner: On the b	asis of examinat	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	e, and due to the our	cause(s) and mann date and place, and	er as stated. d due to the cause(s)		
thin 2 the omple	Med	one) 29b. Signature and title of certifier	and man	ner stated.		29c. Licen	ise number		29d. Date signed (I	Month Day Voes		
1 3 1 8		-	X			Dy	13091		9-15.	08		
31	ŀ	30. Name and address of person w	who completed caus	se of death (Item	23a) (Type	Print)	• •					
			ich' MA	(1011)	801 70	ic Hou	se Ave	, Frea	levick,	MD 2179		
Stat	te	31. Date filed (Month, Day, Year)		tegistrar's Signa	ture	1 4.						
Registra	ar	CED 1	8 2008	193.2.40	D. A	TO SHOW						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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errence S. Edmonds	State of Maryland / Department of Health and Mental Hygier

7			•	
State of Maryland /	Department of	Health and	Mental	Hygiene

	1- For State Certificate of Registrar	Death	Reg. No.	00 3147
Physician/ ledical Examine	Decedent's Name (First, Middle,Last) Constant Con	Edmonds	2. Date of Death Month Day Year September 25, 2008	3. Time of Death 1640 hrs
	4a. Facility Name (if not institution, give street and number) 4 Western Maryland Health System	o. City, Town, or Location of Death Cumberland	Allegany	100
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 230-06-3370 1X M 2 F 46 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Min	Fore	Birthplace (State or eign Virginia Country)
ow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Allegany Cum	n perland		10d. Inside City Limits 1 XYes 2 No
5-0036 led within 72 hours after death with the Maryland 4-tygene. other than "matural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Completed by Furneral Director	10e. Street and Number 205 Baltimore Avenue, Apt 28	10f. Zip Code 21502	10g. Citizen of What Co	puntry?
or items 233	11. Marital Status 1 \(\overline{\chi} \) Never Married 2 \(\overline{\chi} \) Married 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\overline{\chi} \) Yes 2 \(\overline{\chi} \) No	Decedent of Hispanic Origin? (Ss, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	
"natural", c	3 Widowed 4 Divorced II 188, Give 1881	Yes 2 X No specify: s Usual Occupation (Give kind of st of working life. DO NOT use re		Black ss/Industry
21215-0036 Auld be filed within 72 hour Montal Hygene. marked other than "matu c event, the Medical Exan	12 La 17. Father's Name (First, Middle, Last)		Landscar e (First, Middle, Maiden Surname)	
2121 2121 Juld be fi I Mental I marked ic event,	Thomas Curtis Edmonds,		Elizabeth Rural Route Number, City or Town, Sta	Johnson ate, Zip Code)
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If Item 27 is injury or other traumat	1 Burial 2 X Cremation 3 Removal from State crematory or oth 4 Donation 5 Other Specify: Cumberland	ion (Name of cemetery, er place) d Crematory 09 ame and Address of Facility Ad.	Richmond, VA 232 Date 20c Location - City /27/2008 Cumber la ams Family Funeral t, Cumberland, MD	or Town, State
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head injuries Due to (or as a consequence of):			Approximate Interval Between Onset and Death
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uissase or injury that illitiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit	_ I	per ME g884 10/	122122	
lox 68' leath certiff eath certiff for use as		al death 3 Ectopic pregrer (Specify)	23d. Date of deliving Month	very Day Year
i, P.O. B ires that the d signed by the 1 be detached		nderlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 ✓ No 3 F	Probably 4 Unknown
Division of Vital Records, P as the law requires to affect death. The Tan Director: After this certificate has been sign led in by the funeral director, page 2 should be contificated by the funeral director.				
ician: The ician: The sector, page	25. Was case referred to medical examiner?	26.Place of Death (Check 3 DOA Other Nurs		ther:
ision of Vital Rec Attending Physician: The Tractath. The tractath. Other this certificate by the funeral director, page	27 Manner of Death 28a Date of Injury 28h Time of Ir	0 001	28d. Describe how injury occurred	
Sion Attendin death. xctor: A xy the fu	Natural 5 Pending 9/23/08 Fnd 1:5		subject fell	
Division or Hospital or Attending 24 hours after death Funeral Director: Aftered in by the funeral Contification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street found in ditc	t, factory, office building, etc.	28f. Location (Street and Number or or Town, State) 201 Bal Cumberland, MD	Rural Route Number, City timore St.
To the Hos within 24 h To the Fur completely		on, in my opinion, death occurred	at the time, date and place, and due to	the cause(s)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (i	
	30. Name and address of person who completed cause of death (Item 23a)	Penn Street, Baltimore, I		
Stat	Loo D. M. J. Charles	South a		

OCME

08-07180	
Michael Ealey	

8-07180 lichael Ealey		Please Type or Print in Black Index State of Maryland / Depart						0000110
ionaer =arey		1- For State Certif	ficate of		iu Mentai		2 () I	08 3149
Physicia	ın/	Decedent's Name (First, Middle,Last)			100	2. Date of Death Month		3. Time of Death
ledical Exami	ner	Michael Ealey				September	20, 2008	12:17 pm
		4a. Facility Name (if not institution, give street and number) 22930 Shiloh Church Road		Boyds	or Location of De	eath	4c. County of Dea Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Ye			h (MM/DD/YYYY) 9. E	
Director		091-52-7177 1XM 2_F 40	Yrs	Months Da	lys Hours I	Aug. 9	, 1968 J	Country New York
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Locat	ion				10d. Inside City Limits
*	٦	Maryland Montgomery (German	town				1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
th the 23a or notifie		20421 Ambassador Terrace	1	208			United	States
ath wi	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?			lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,
fter de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X N	lo specify:		Specify: B	lack
nours a	ed by				ation (Give kind fe. DO NOT use		16b. Kind of Busines	s/Industry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Sal	-		,	Auto	motive
5-00 ed with tygien other	Con	17. Father's Name (First, Middle, Last)			18.Mother's Na	ame (First, Middle, M		
121 d be fil ental F arked vent,	a	Ernset Ealey				ce Edwards		
D 2 should and M 7 is m	욘	19a. Informant's Name/Relationship (Type, Print)					ber, City or Town, Sta	
e, M and 2 Health item 2			2042 ce of Dispos	L Ambas ition (Name of c	sador Te emetery,	errace, Ge	rmantown, 20c. Location - City	MD 20874 or Town, State
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental 1 tant: If item 27 is marked or other traumatic event,			matory or otl iffer	nerplace) Cremato:	ry 9,	/29/2008	Frederic	k, Maryland
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Solution of Funeral Service Licensee	22. N	lame and Addre	ss of Facility	Stauffe	er funeral	Home
		233. Part I. Enter the ofsease, or complications that redised the death. Do	not enter t	1621 Op	ossumto			
Physician /Medical	9	failure. List only one cause on each line.			*.	ac or respiratory arre	st, shock, or near	Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or rer	t WIISt				
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Gause (Disease or injury that initiated						
cuted nd transit	Exa	events resulting in death) Last Due to (or as a consequence of):						
an a	jical	XUNPENDED X AMENDED #2,23a,2	7,28a-	f, perM	E, g886	12/18/08	TT	
Box 68760, e death certificate be except the attending physician ed for use as the burial -	Physician/Medica	IF FEMALE: 23c. If yes, outcome of pregnar 23b. Was decedent pregnant in the	псу				23d. Date of deliv	
certification of the centing the as	cian	past 12 months? 1 Live birth Pregnant at time of death	_ =	tal death 3 her (Specify)	Ectopic pre	egnancy	Month	Day Year
BOy e death the att	hysi	1 Yes 2 No 9 Unknown g Unknown			-			
P.O. that the	by P	Part II. Other significant conditions contributing to death but not resu	liting in the u	ınderlying cause	e given in Part I.			to the cause of death?
ords, P.C w requires that is been signed be should be deta						24a. Was a		autopsy findings available
cor e law r e has b	Completed					autops perform	med? death	
tal Rection: The l	ပ္ပ	25. Was case referred to medical		26.Pla	ce of Death (Che	1 Yes 2	2 No 1	Yes 2 No
Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 EF	₹/Outpatient		1Other:		Residence 6 🗸 Oth	ner: Scene
Division of Vital Records, P. Isl or Attending Physician: The law requires the rafter death. In Director: After this certificate has been signed in by the funeral director, page 2 should be defined in by the funeral director, page 2 should be defined in by the funeral director.	崩	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	Bb. Time of I		jury at Work?		ow injury occurred cut himse	.1 f
Sior Attend r death ector: by the	catio	2 Accident Investigation Fd 9/20/08 Fd	1 12:1	. Դ Իւր	Yes 2 X No			
DIVI	Certification:	3 \overline{X} Suicide 6 Could not be determined 28e. Place of Injury - At home F Found in F Side	parke	d vehic	le on	or Town, St		Rural Route Number, City 1110h Church
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occur	red at the time,		and due to the cause	e(s) and manner as st	
To the Howithin 24 F	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.	or investigat		on, death occurre		and place, and due to	

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year)
Registrar SEP 2 9 2008

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

September 21, 2008

	For State of Mai	ryland / Depa	irtment of He <i>tificate of D</i>		lental Hyg	iene	100 0	1107
	1. Decedent's Name (First, Middle, Last)	JU0 3	me of Death					
Physician /Medical	Galen Ray Evler	Year	:30 p.M					
Examiner	4a. Facility Name (If not institution, give street and number)	•	4c. County of Death					
Funeral	9746 Daysville Road 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Walkersv If Under 1 Year	TILLE If Under 24 Hrs.	8. Date of Birth		9. Birthplace (S	State or Foreign
Director	217–32–6064 ¹ 3x ^M ² F 78	Yrs.	Months Days	Hours Min.	(Month, Day, Aug 8,		Maryland	
land t	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Ins	ide City Limits
Mary a-f sho ified a	Maryland Frederick	Walkersvi	i1e					Yes 2y No
ifter death with the Mar r Items 23a or 28a-f si liner must be notified Funeral Director	10e. Street and Number 9746 Daysville Road		10f. Zip Code 21793		10	g. Citizen of USA	What Country?	
urs a urs a sam sam sam sam sam sam sam sam sam	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Vas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spo Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - American Indi ack, White, etc. white	
ed within 72 holygiene. The Medical Et, the Medical ECompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	ent's Usual Occupati kind of work done du OO NOT use retired)	on ring most of work	ing		Business/Industry	
2 should be filed with and Mental Hygiene. is marked other than aumatic event, the M	17. Father's Name (First, Middle, Last)	Dairy	farmer	8. Mother's Name	e (First, Middle, N	farı Naiden Surna		
tould by an arked natic evaluation	James Albert Eyler				lary Iren			
122 ha	19a. Informant's Name/Relationship (Type. Print) Bonnie Snyder – niece		g Address (Street an Oak Tree					1701
permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.	20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, cren Rocky Hil	sition (Name of natory or other place) L1 Cemeter	y 9–18–			- City or Town, Staro, Mary	
permit. Departi	21. Signature of Funeral Service Licensee	ling 1	Name end Address 621 Oposs	umtown P	ike, Fre	deric		nd 2170
Physician /Medical Examiner phuial-transit printing - Familie - Fa	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate failure. Due to (or as a condition or condition). Sequentially list conditions, if any, leading to immediate failure. Due to (or as a condition). Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition).	Interv	ximate					
ificate be g physicia as the bur edical								
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tii	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				ate of delivery onth Day	Year
w requires that been signed be should be deta	Part II. Other significant conditions contributing to death but		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ⊡ Unknown					
					24a. Was an autopsy perform	ned?_	Were autopsy find prior to completio death?	n of cause of
sician: certific rector,	25. Was case referred to medical examiner?		0.11	6. Place of Death	(Check only one			
Physical distribution of the standard distrib	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient			me 5 Aeside 28d. Describe ho			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification; To Be C	1 ☐ Natural 5 ☐ Pending (Month, Day') 2 ☐ Accident investigation	(rear) Injury		s 2 No		eet and Num	ber or Rural Route	Number,
o the Hospital ithin 24 hours a o the Funeral I ompletely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of earnd manner state	xamination and/or inv	occurred at the time, estigation, in my opin	, date and place, nion, death occurr	and due to the ca red at the time, da	use(s) and mate and place	nanner as stated. , and due to the ca	use(s)
To the I within 2 To the I Complet	29b. Signature and title of certifier		29c. License n		29	1 1	ed (Month, Day, Yo	ear)
(1)	30. Name and eddress of person who completed cause of dea Kusay Barakat	th (Item 23a) (Type, F 310 W. 9t		Frederic	ck, Mary	land	21701	
State Registrar	21 Date filed (Month Day Year) 20 Docthron's							

	1 _ s	or itate	Pleas				d / Depa	delible Ink artment of F r <i>tificate of</i>	Health and M	Mental Hy		0000	311.98
Physician	1. Dec	legistrar cedent's Nam oseph	e (First, Middle,	Last)	Frant			inoute or	Douth	2. Date of Dea Month 09	Rose	Year 2008	3. Time of Death 6:25 P
/Medical Examiner	4a. Fa	cility Name (i	If not institution,	•	and number)				or Location of Death		4c. C	County of Dea	
Funeral Director	5. Soc	car Hi Security N 7-03-4		Sted 6. Sex 1 X M 2	7. Ag		last birthday) Yrs.	Accident If Under 1 Year Months Days		8. Date of Birt (Month, Da)	h y, Yea <i>r)</i>	C	rthplace (State or Foreign ountry)
ryland how	Usual 10a. S	Residence o					y, Town or Lo	cation			1910	na	ryland 10d. Inside City Limits
th the Ma or 28a-f s e notified	10e. S	MD Garrett Ac						ccident 10f. Zip Code					1 □ Yes 2 🛣 No ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	13 11. Ma	arital Status	endorf	12. Wa	s Decedent ned Forces? Yes 2 ☐ I			21520 Was Decedent of Hold Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No o Rican, etc.)		USA 4. Race - Ame Black, Whi	te, etc.
"natural", dical Exa	35		4 ☐ Divorced 15. Decedent' cify only highes	Ye s Education	ar or Dates:		16a. Dece	dent's Usual Occur		king		Specify: Williams d of Business	hite /Industry
iled within 72 hou Hygiene. Ther than "natura nt, the Medical E nt, the Medical E	Eler	mentary/Secondar			llege (1-4or 5	5+)	1	rician/				lf emp	loyed
ould be fill Mental H harked oth natic even	P	erry	Frantz						Ardath	Cale			
and 2 sh ealth and n 27 Is m			ame/Relationsh		nt)		1900	3 Old Ba	and Number or Ru 1 timore F	Rd. Broo			,
Pages 1 nent of He int: If iten iry or oth	1		position ☐Cremation 5 ☐ Other (Sp		Il from State	C	emetery, crei	sition (Name of matory or other pla Cemetery	i	Date / 2008		ation - City of	r Town, State Maryland
permit. Departn Importa any Inju	21. Si	ignature of	unera Service t	icensee	1		22	2. Name and Addre	ess of Facility F	redlock	Fune	ral Ho	me
Physician /Medical Examiner	shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death
ite be executed sysician and re burial-transit													
: The law requires that the death certificate I cate has been signed by the attending physic page 2 should be detached for use as the t. Completed by Physician/Medica	IF FEI 23b. V ii	MALE: Was deceden in the past 12 1 □ Yes 2[9 □ Unknown	months? ☐ No	1 D 4 D	res, outcome Live birth Pregnant at Unknown	2 ☐ Fetal	Ideath 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		2;	3d. Date of de Month	elivery Day Year
w requires that the debeen signed by the should be detached each of the bear of the by the should by Physical by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use of the underlying cause given in Part I.										to the cause of death?		
i: The law red licate has been r, page 2 shou										24a. Was autop perfo 1∐ Yes	autopsy prior to completion of cause of death?		
To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	25. Was case referred to medical examiner? 1 Yes 2											Cachal	
o the Hospital or ithin 24 hours afte to the Funeral Dia ompletely filled in	29a. 0	Certifier (Check only	1 Certifying 2 Medical E	xaminer: O	To the best	of my kno	wledge, deat	n occurred at the ti	ime, date and place	City or Tov , and due to the irred at the time,	cause(s)	and manner a	is stated.
To the within 2 To the complet	29b. S	one) Signature and	title of certiffer	ar	d manner st	ated.		29c. Licens	0				oth, Day, Year)
8		ame and add					23a) (Type,					19,8	
State Registrar	_ D	ate filed (Mon	ert A. oth, Day, Year) EP 2 2	Goral: 2008	ski, 3			th Street	, Oaklan	d, MD 21	550		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\gamma_{\rm e}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 24, **Physician** 2008 William George Fisher /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 800 Motter Avenue, Apt. 314 Frederick Frederick 7. Age (In yrs. last birthday)
74 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 10 5. Social Security Number 6. Sex 1 XM 2 ☐ F 9. Birthplace (State or Foreign **Funeral** Maryland Days Months Hours 216-30-2942 1934 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2X No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 800 Motter Avenue, Apartment 314 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No If Yes, Give Year or Dates: Specify. White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, in "Moto. once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George William Roosevelt Fisher Anna Elizabeth Releford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allie M. Fisher / Wife 800 Motter Ave. #314, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 29, 2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens Keeney & Basiord PA Funeral Home 106 E. Church Street, Frederick, 21. Signature of Funeral Service Licensee MO1473 Maryland 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner Altery disease COVONAVY Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events in death) I as the conditions of the cause o Physician/Medical Examiner be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 ☐ Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has I page 2 s certificate 2 No 2 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician; : After this certific e funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and fit 29c. License number ertifier 29d. Date signed (Month, Day, Year) 10062127

DHMH 17 Rev 1/2001

Registrar

State

ORIGINAL

BOLALUM

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAYERN

31. Date filed (Month, Day, Year)

OCT

September 25, 2008

196 TJ DLIVE, FLGNELICE, HD-21702

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Sept. 2008 5:10 AM Be11 Graham /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dennett Road Manor Nursing Home 0akland Garrett If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 7, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** W̃irgin<u>ia</u> **Director** 215-20-7247 West Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at Director 1 ☐ Yes 2 ☐ No MD Garrett 0ak1and 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 765 Crellin Mine Road 21550 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ∐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 LXNo Specify <u>6</u> Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Mersing Clara Bel1 White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freda Martin, Daughter 765 Crellin Mine Road, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ashby Cemetery 9/24/08 4 ☐ Donation 5 ☐ Other (Specify) Crellin, MD 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. 21. Signature of Funeral Service Licensee Katherine 21_N. Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that aused the thath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown , page 2 should be detach Part II. Other significant conditions contributing to death out resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 1 Narsing Home Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manney Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause ath (Item 23a) (Type, Print) Savopoulos Oakland Sotiere 255 N. 21550 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 2008 25 Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760.

of Vital Records,

Division